**दि ओरिएण्टल इंश्योरेंस कम्पनी लिमिटेड**

**THE ORIENTAL INSURANCE COMPANY LIMITED**

**पंजीकृत कार्यालय :- ओरिएण्टल हाऊस, पो.बॉ. नं- 7037, ए-25/27 आसफ अली रोड, नई दिल्ली**

**Regd. Office: Oriental House, P.B. No. 7037 A-25/27, Asaf Ali Road, New Delhi**

# POLICY

**Issuing Office**

**UNIVERSAL HEALTH INSURANCE POLICY (GROUP)**
**UIN: OICHLGP21549V022021**

1. WHEREAS the insured designated in the Schedule hereto has by a proposal and declaration dated as stated in the Schedule which shall be the basis of this Contract and is deemed to be incorporated has applied to THE ORIENTAL INSURANCE COMPANY LIMITED (hereinafter called the COMPANY) for the insurance hereinafter set forth in respect of Insured Person(s)/Members (including their eligible family members) named in the Schedule hereto (hereinafter called the INSURED PERSON) and has paid premium as consideration for such insurance.

1.1 Subject to the terms, conditions, exclusions and definitions contained herein or endorsed, or otherwise expressed here on the Company undertakes that if during the period stated in the Schedule any insured person shall suffer from any disease or illness (hereinafter called DISEASE) or sustain any bodily injury through accident (hereinafter called INJURY) and if such disease or injury shall require any such insured Person, upon the advice of a duly qualified Physician/Medical Specialist/Medical practitioner (hereinafter called MEDICAL PRACTITIONER) or of a duly qualified Surgeon (hereinafter called SURGEON) to incur hospitalisation expenses for medical/surgical treatment at any Nursing Home/Hospital in India as herein defined (hereinafter called HOSPITAL) as an inpatient, the Company will pay through TPA to the Hospital / Nursing Home or Insured Person the amount of such expenses subject to limits as are reasonably and necessarily incurred in respect thereof by or on behalf of such Insured Person but not exceeding the Sum Insured for that person (all claims in aggregate) in any one period of insurance stated in the schedule hereto.

1.2 In the event of any claim becoming admissible under this scheme, the company will pay through TPA to the Hospital / Nursing Home or insured person the amount of such expenses as would fall under different heads subject to limits mentioned below and as are reasonably and necessarily incurred thereof by or on behalf of such insured person.

**Section – I HOSPITALISATION EXPENSES**

| **Hospitalisation Benefits** | | **Limits** |
|---|---|---|
| A | i) Room, Boarding Expenses as provided by the Hospital / nursing home.<br>ii) If admitted in IC Unit | i) Up to 0.5% of Sum Insured per day<br>ii) Up to 1% of Sum Insured per day |
| B | Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees, Nursing Expenses | Up to 15% of Sum Insured per illness / Injury |
| C | Anaesthesia, Blood, Oxygen, Operation Theatre Charges, surgical appliances, Medicines & Drugs, Diagnostic Materials and X-ray Dialysis, Chemotherapy, Radiotherapy Cost of Pacemaker, Artificial Limbs & Cost of organs and similar expenses. | Up to 15% of Sum Insured per illness / Injury |

| | | |
|---|---|---|
| D | Maternity Benefit ***(****Maternity Expenses and New Born child cover****)*** – ONE CHILD ONLY<br>(with 12 months waiting period) | Rs.2,500/- for normal delivery and Rs.5,000/- for caesarean/*extra uterine delivery*. |

**(a)** Company's Liability in respect of all claims including Maternity Benefit admitted during the period of Insurance shall not exceed the Sum Insured of Rs.30,000/- per person or family as mentioned in the schedule).
**(b)** Total expenses incurred for any one illness is limited to Rs.15000/- (other than Maternity Benefit)
**(c)** The Policy is extended to include one Maternity Benefit with liability under the Section being restricted to Rs.2,500/- for normal delivery and Rs.5,000/- for caesarean/*extra uterine delivery*. A waiting period of 12 months from inception of the policy is applicable. The above amount would also cover the medical expenses incurred in respect of new born child upto 3 months. However, this Maternity Benefit is within the overall limit of Sum Insured of Rs.30,000/-
**(d)** Total expenses incurred for any one illness is limited to Rs. 15,000/-
**(e)** This benefit is available only once to an insured person during the currency of the policy or its subsequent renewals. i.e. only once during the life time of insured person..

**Following covers are also included in the policy:**

**Telemedicine-**
Expenses incurred by insured on telemedicine/Tele-consultation with a registered medical practitioner for Diagnosis & treatment of a disease/illness covered under the Policy. Such reasonable incurred expenses will be reimbursable wherever consultation with a Registered medical practitioner is allowed in the terms and conditions of policy contract and shall be subject to Limits/Sub limits prescribed in Policy Schedule. Telemedicine offered shall be in compliance with the Telemedicine Practice Guidelines dated 25th of March 2020 by MCI and as amended from time to time." The limit of amount payable for telemedicine is Maximum Rs. 2,000/-per insured &/or per family, for a policy period.

**HIV/ AIDS Cover**
The Company shall indemnify the Hospital or the Insured the Medical Expenses (including Pre and Post Hospitalization Expenses) related to following stages of HIV infection:
a. Acute HIV infection – acute flu-like symptoms
b.Clinical latency – usually asymptomatic or mild symptoms
c. AIDS – full-blown disease; CD4 < 200

**MENTAL ILLNESS COVER**
The Company shall indemnify the Hospital or the Insured the Medical Expenses (including Pre and Post Hospitalization Expenses) only under certain conditions as:-
1. Illness covered under definition of mental illness*.
2. Hospitalization in Mental Health Establishment as defined under definitions clause*.
3. Hospitalization as advised by Mental Health Professional as defined under definitions clause*.
4. Mental Conditions associated with the abuse of alcohol and drugs are excluded.
5. Mental Retardation and associated complications arising therein are excluded.
6. Any kind of Psychological counselling, cognitive/ family/ group/ behavior/ palliative therapy or other kinds of psychotherapy for which Hospitalization is not necessary shall not be covered.

* For starred items, refer definitions clause.

**DEFINITIONS:**

**ACCIDENT**: is a sudden, unforeseen and involuntary event caused by external, visible and violent.

**AMBULANCE SERVICES**: means ambulance service charges reasonably and necessarily incurred in shifting the insured person from residence to hospital for admission in emergency ward / ICU or from one Hospital / Nursing Home to another Hospital / Nursing Home, by registered ambulance only. The ambulance service charges are payable only if the hospitalisation expenses are admissible under the policy.

**AYUSH:** AYUSH treatment refers to the Medical and/or hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy systems.

**ANY ONE ILLNESS**: means continuous period of Illness and it includes relapse within 45 days from the date of last consultation with the Hospital /Nursing Home where treatment was taken.

**CASHLESS FACILITY**: means a facility extended by the insurer to the insured where the payments of the costs of the 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 of pre- authorization approved.

**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:** which is not in the visible and accessible parts of the body

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

**CONDITION PRECEDENT:** means a policy term or condition upon which the Insurer's liability under the policy is conditional**.**

**CO-PAYMENT:** is a -sharing requirement under a health insurance policy that provides that the policy holder/insured cost will bear a specified percentage of the admissible claim amount. A Co-payment does not reduce the Sum Insured.

**DAILY HOSPITAL CASH ALLOWANCE:** When an insured person is hospitalized and a claim is admitted under the policy, then the insured person shall be paid a daily cash allowance as specified in section 1.2 A (f). However, a deductible of 2 days per hospitalization shall apply, i.e Daily cash allowance will become payable from the third day onwards of continuous hospitalization.

**DAY CARE CENTRE:** means any institution established for day care treatment of illness and / or injuries OR a medical set -up 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 will make these accessible to the Insurance company's authorized personnel.

**DAY CARE TREATMENT:** refers to medical treatment, and/or surgical procedure which is:

i. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
ii. which would have otherwise required a hospitalization of more than 24 hours.

Procedures / treatments usually done in out patient department are not payable under the policy even if converted to Day Care surgery / procedure or taken as an in patient in a hospital for more than 24 hours.

**DEDUCTIBLE**: is a cost-sharing requirement under this policy that provides that the Company will not be liable for a specified period, which will apply before any Benefits are payable by the Company. A deductible does not reduce the Daily Cash Benefit Period. Deductible is applicable per event.

**DOMICILIARY HOSPITALISATION :** means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances

**(i)** the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or

**(ii)** the patient takes treatment at home on account of non availability of a room in a hospital.

**DENTAL TREATMENT:** Dental treatment means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and Surgery

**FAMILY:** consists of the proposer and any one or more of the family members as mentioned below:

i. legally wedded spouse.

ii. dependent Children (i.e. natural or legally adopted) between the age 3months to 18 years. However male child can be covered upto the age of 25 years if he is a bonafide regular student and financially dependent on the proposer. Female child can be covered until she gets married. Divorced and widowed daughters, are also eligible for coverage under the policy, irrespective of age. If the child above 18 years is financially independent or if the girl child is married, he or she shall be ineligible for coverage in the subsequent renewals.

iii. Parents / Parents-in-law (either of them).

iv. Unmarried siblings, if financially dependent on the Insured.

**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.

**HOSPITAL/NURSING HOME:** means any institution established for in- patient care and day care treatment of Illness and / or injuries and which has been registered as a Hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act*OR complies with all minimum criteria asunder:

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 In-patient 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.

*Following are the enactments specified under the schedule of Section 56 of Clinical Establishment (Registration and Regulation) Act, 2010 as of October 2013. Please refer to the Act for amendments, if any:

1. The Andhra Pradesh Private Medical care Establishments (Registration and Regulations) Act, 2002

2. The Bombay Nursing Homes Registration Act, 1949

3. The Delhi Nursing Home Registration Act, 1953

4. The Madhya Pradesh Upcharya Griha Tatha Rujopchar Sanbadhu Sthapamaue (Ragistrikaran Tatha Anugyapan)Adhiniyam, 1973.

5. The Manipur Homes and Clinics Registration Act, 1992.

6. The Nagaland Health Care Establishments Act, 1997

7. The Orissa Clinical Establishments (Control and Regulations) Act, 1990

8. The Punjab State Nursing Home Registration Act, 1991

9. The West Bengal Clinical Establishment Act, 1950

**HOSPITALISATION:** means admission in a Hospital for a minimum period of twenty four (24) in-patient care consecutive hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours**.**

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

**INSURED PERSON :** means person(s) named in the schedule of the policy

**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.

**a. 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** - is a disease, illness, or injury that has one or more of the following characteristics:

i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests

ii. it needs ongoing or long-term control or relief of symptoms

iii. it requires rehabilitation or to be specially trained to cope with it

iv. it continues indefinitely

v. it comes back or is likely to come back.

**INJURY:** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.

**IN-PATIENT:** means an Insured person who is admitted to hospital and stays for at least 24 hours for the sole purpose of receiving the treatment for suffered ailment / illness / disease / injury / accident during the currency of the policy.

**I .D. CARD:** means the card issued to the Insured Person by the TPA to avail Cashless facility in the Network Hospital.

**MEDICAL ADVICE**: means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

**MEDICAL EXPENSES:** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of disease 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.

**MEDICALLY NECESSARY TREATMENT:** 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.

**MEDICAL PRACTITIONER:** means a person who holds a valid registration from the Medical Council of any state or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.

**NETWORK PROVIDER:** means Hospitals or healthcare providers enlisted by an insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a cashless facility.

**NON-NETWORK**: Any Hospital, day care centre or other provider that is not part of the Network.

**NOTIFICATION OF CLAIM**: means the process of intimating a claim to the Insurer or TPA through any of the recognized modes of communication.

**OPD TREATMENT**: is 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.

**PRE-HOSPITALISATION EXPENSES:** means medical expenses incurred during the period upto 30 days prior to the date of admission in the hospital, provided that:

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

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

**POST-HOSPITALISATION EXPENSES:** means medical expenses incurred for a period upto 60 days from the date of discharge from the hospital, provided that:

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

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

**PRE EXISTING DISEASE:** means any condition, ailment or 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.

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.

**POLICY PERIOD:** means the period of coverage as mentioned in the schedule

**PORTABILITY:** means transfer by an individual health insurance policy holder (including family cover) of the credit gained for pre-existing conditions and time-bound exclusions if he/she chooses to switch from one insurer to another.

**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.

**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 .

**ROOM RENT:** means the amount charged by a Hospital towards room and boarding expenses and shall include the associated medical expenses.

**SUBROGATION:** means the right of the Insurer to assume the rights of the Insured Person to recover expenses paid out under the policy that may be recovered from any other source.

**SURGERY/ SURGICAL OPERATION**: 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 of suffering or prolongation of life, performed in a hospital or a day care centre by a medical practitioner

**THIRD PARTY ADMINISTRATOR (TPA):** means any person who is licensed under the IRDA (Third Party Administrators – Health Service) Regulations, 2001 by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services.

**UNPROVEN/EXPERIMENTAL TREATMENT:** Treatment means the treatment including drug drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

**AYUSH Hospital:**

An AYUSH Hospital is a healthcare facility wherein medical/surgical/Para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

**a.** Central or State Government AYUSH Hospital; or

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

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

i. Having at least five in- patient beds;

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

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

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

**AYUSH Day Care Centre:**

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

**i.** Having qualified registered AYUSH Medical Practitioner (s) in charge.
**ii.** Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
**iii.** Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

**Migration** : "Migration" means, the right accorded to health insurance policy holders (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

**Portability:** "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.

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

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

**Mental health professional:**
(i) a psychiatrist or
(ii) a professional registered with the concerned State Authority under section 55; or
(iii) a professional having a post-graduate degree (Ayurveda) in Mano VigyanAvum Manas Roga or a post-graduate degree (Homoeopathy) in Psychiatry or a post-graduate degree (Unani) in Moalijat (Nafasiyatt) or a post-graduate degree (Siddha) in SirappuMaruthuvam.

**EXCLUSIONS:** The Company shall not be liable under this section for disablement / death of the Insured Person i. on account of Intentional self-injury, suicide or attempted suicide
ii. Whilst under the influence of intoxicating liquor or drugs
iii. Whilst engaging in any hazardous activity including, but not limited to aviation or ballooning, speed contests or racing of any kind(other than on foot), bungee jumping, parasailing, parachuting, ski-diving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving using hard helmet and breathing apparatus, polo, snow and ice sports or involving a military, air force or naval operations, or whilst mounting into, dismounting from or travelling in any aircraft other than as a passenger (fare paying or otherwise), in any duly licensed standard type of aircraft, anywhere in the world.
iv. Directly or indirectly caused by venereal disease(s) or insanity
v. Arising or resulting from insured committing breach of law with criminal intent

vi. 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, arrest, restraints and detainments of people

vii. directly or indirectly caused by or arising from ionizing radiations or contamination by radioactivity from any nuclear fuel, nuclear weapon material, or from any nuclear waste from the combustion of nuclear fuel,

viii. Directly or indirectly caused by, contributed to, aggravated or prolonged by childbirth or from pregnancy or in consequence thereof.

### 3. EXCLUSIONS: Waiting Period:

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

**Pre-existing Diseases - code –Excl 01**

a). Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with the insurer or its reinstatement.

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 the prior coverage.

d). Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by insurer or its reinstatement.

**Specified disease / procedure waiting period- code- Excl 02**

a). Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of the specified waiting period of the continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.

b). in case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c). If any of the specified disease/ procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.

d). The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.

e). If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

f). The expenses on treatment of following ailments / diseases / surgeries, if contracted and / or manifested after inception of first Policy(subject to continuity being maintained), are not payable during the waiting period specified below.

| | **Ailment / Disease / Surgery** | **Waiting Period** |
|---|---|---|
| i | Benign ENT disorders and surgeries i.e. Tonsillectomy, Adenoidectomy, Mastoidectomy, Tympanoplasty etc. | **1** year |
| ii | Polycystic ovarian diseases. | **1** year |
| iii | Surgery of hernia. | **2** years |
| iv | Surgery of hydrocele. | **2** years |
| v | Non infective Arthritis. | **2** years |
| vi | Undescendent Testes. | **2** Years |
| vii | Cataract. | **2** Years |

| | | |
|---|---|---|
| viii | Surgery of benign prostatic hypertrophy. | **2** Years |
| ix | Hysterectomy for menorrhagia or fibromyoma or myomectomy | **2** Years |
| x | Fissure / Fistula in anus. | **2** Years |
| xi | Piles. | **2** Years |
| xii | Sinusitis and related disorders. | **2** Years |
| xiii | Surgery of gallbladder and bile duct excluding malignancy. | **2** Years |
| xiv | Surgery of genito-urinary system excluding malignancy. | **2** Years |
| xv | Pilonidal Sinus. | **2** Years |
| xvi | Gout and Rheumatism. | **2** Years |
| xvii | Hypertension. | **90 days*** |
| xviii | Diabetes. | **90 days*** |
| | *Subject to application of condition 21 of the policy. | |
| xix | Calculus diseases. | **2** Years |
| xx | Surgery for prolapsed inter vertebral disk unless arising from accident. | **2** Years |
| xxi | Surgery of varicose veins and varicose ulcers. | **2** Years |
| xxii | Congenital internal diseases. | **2** Years |
| xiii | Joint Replacement due to Degenerative condition. | **4** Years |
| Xxiv | Age related osteoarthritis and Osteoporosis. | **4** Years |

**If the above diseases are pre-existing at the time of inception, Exclusion no.4.1 for pre-existing disease shall be applicable.**

**Note**: If the continuity of the renewal is not maintained then subsequent cover will be treated as fresh Policy and clauses 4.1., 4.2, 4.3 shall apply afresh, unless agreed by the Company and suitable endorsement passed on the Policy, by the duly authorized official of the Company. Similarly, if the Sum Insured is enhanced subsequent to the inception of the first Policy, clauses 4.1, 4.2 and 4.3 shall apply afresh on the enhanced portion of the Sum Insured.

**4.3 30 day waiting period- code – Excl 03**

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.

**GENERAL EXCLUSIONS:** The Company shall not be liable to make any payment under this Policy in respect of any expense whatsoever incurred by any Insured Person in connection with or in respect of:

**Investigation & Evaluation – Code – Excl 04**

**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.

**Rest Cure, rehabilitation and respite care – Code –Excl 05**

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 a 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.

**Obesity/Weight Control : Code- Escl 06**

Expenses related to the surgical treatment of obesity that does not fulfill all the below conditions:

1). Surgery to be conducted is upon the advice of the Doctor.

2). The surgery /Procedure conducted should be supported by clinical protocols.

3). The member has to be 18 years of age or older and

4). Body Mass Index (BMI):

a) greater than or equal to 40 or

b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failures of less invasive methods of weight loss:

i). Obesity – related cardiomyopathy

ii). Coronary heart diseases

iii). Severe Sleep Apnea.

iv). Uncontrolled Type 2 Diabetes.

**Change of Gender Treatments : Code – Excl 07**

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite.

**Cosmetic or Plastic Surgery- Code- Excl 08**

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an accident, burns(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 theattending Medical practitioner.

**Hazardous or Adventure sports- Code- Excl 09**

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.

**Breach of law – Code –Excl 010**

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

**Excluded Providers- Code – Excl 011**

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 policy holders are not admissible. However, in case of life threatening situations or following an accident, expenses upto the stage of stabilization are payable but not complete claim.

Treatment for, Alcoholic drug or substance abuse or any addictive condition and consequences thereof. – Code-ExcI01

Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons.- Code- ExcI013

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- ExcI014

**Refractive Error- Code- Excl 015**

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

**Unproven Treatments- Code – excl 016**

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.

**Sterility and Infertility- Code- Excl 017**

Expenses related to sterility and infertility. This includes:

i). Any type of contraception, sterilization.

ii). Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI.

Iii). Gestation Surrogacy. iv). Reversal of sterilization.

**Maternity- Code- Excl 018**

**i).** Medical treatment expenses traceable to childbirth ( including complicated deliveries and cesarean sections incurred during hospitalization) except ectopic pregnancy.

**ii).** Expenses towards miscarriage( unless due to an accident) and lawful medical termination of pregnancy during the policy period. (The above exclusion is not applicable in Diamond Plan to the extent given under 1.5)

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

**a)** Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion: Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

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

**c)** Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

Any expenses incurred on OPD treatment.

Treatment taken outside the geographical limits of India.

Pre and post hospitalization expenses unrelated with disease / injury for which hospitalization claim has been admitted under the policy.

## 4. CONDITIONS

**ENTIRE CONTRACT:** This policy /prospectus/ proposal form and declaration given by the insured constitute the complete contract. Insurer may alter the terms and conditions of this policy/contract. Any alteration that may be made by the insurer shall only be evidenced by a duly signed and sealed endorsement on the policy.

**COMMUNICATION:** Every notice or communication to be given or made under this policy shall be delivered in writing at the address of the policy issuing office / Third Party Administrator as shown in the Schedule.

**PAYMENT OF PREMIUM:** The premium under this policy shall be paid in advance. No receipt for premium shall be valid except on the official form of the Company signed by a duly authorized official of the Company.

The due payment of premium and the observance and fulfillment of the terms, provisions, conditions and endorsements of this policy by the Insured Person in so far as they relate to anything to be done or complied with by the Insured Person shall be condition precedent to any liability of the Company to make any payment under this policy. No waiver of any terms, provisions, conditions and endorsements of this policy shall be valid, unless made in writing and signed by an authorized official of the Company.

**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.

**NOTICE OF CLAIM:** Immediate notice of claim with particulars relating to Policy Number, ID Card No., Name of insured person in respect of whom claim is made, Nature of disease/injury and Name and Address of the attending medical practitioner/Hospital/Nursing Home etc. should be given to the Company / TPA while taking treatment in the Hospital/Nursing Home by Fax, Email. Such notice should be given within 48 hours of admission but before discharge from Hospital/Nursing Home, unless waived in writing.

**CLAIM DOCUMENTS:** Final claim along with original Bills/Cash memos/reports, claim form and documents as listed below should be submitted to the Company / TPA within 15 days of discharge from the Hospital / Nursing Home.

a. Original bills, all receipts and discharge certificate / card from the hospital.

b. All documents pertaining to the illness, starting from the date it was first detected, i.e Doctor's consultations reports / history

c. Medical history of the patient recorded by the Hospital.

d. Original Cash-memo from the hospital (s) / chemist (s) supported by proper prescription.

e. Original receipt, pathological and other test reports from a pathologist / radiologist including film etc supported by the note from attending Medical Practitioner / Surgeon demanding such tests.

f. Original attending Consultants / Anesthetists / Specialist certificates regarding diagnosis and bills / receipts etc.

g. Surgeon's original certificate stating diagnosis and nature of operation performed along with bills / receipts etc.

h. MLC/FIR/Post Mortem Report,( if applicable)

i. Disability certificate, Death certificate ( if applicable)

j. Details of previous policies, if the details are already not with TPA.

k. Any other information required by Company/TPA.

All documents must be duly attested by the Insured person/claimant.

In case of post hospitalization treatment (limited to 60 days) all supporting claim papers / documents as listed above should also be submitted within 15 days from completion of such treatment ( up to 60 days or actual period whichever is less ) to the
Company / T.P.A. In addition insured Person should also provide the Company / TPA such additional information and assistance as the Company / TPA may require in dealing with the claim.

Waiver of this condition may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time limit. Otherwise Company has a right to reject the claim.

**CLAIM SETTLEMENT (provision for Penal Interest):**

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

iii. However, where the circumstance of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above 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).**

**PROCEDURE FOR AVAILING CASHLESS ACCESS SERVICES IN NETWORK HOSPITAL/NURSING HOME:**

**i)** Claim in respect of Cashless Access Services will be through the Company/ TPA provided admission is in a networked Hospital / Nursing Home and is subject to pre admission authorization. The Company / TPA shall, upon getting the related medical details / relevant information from the insured person / network Hospital / Nursing Home, verify that the person is eligible to claim under the policy and after satisfying itself will issue a pre-authorization letter / guarantee of payment letter to the Hospital / Nursing Home mentioning the sum guaranteed as payable, also the ailment for which the person is seeking to be admitted as in-patient.

**ii)** The Company / TPA reserves the right to deny pre-authorization in case the hospital / insured person is unable to provide the relevant information / medical details as required by the Company / TPA. In such circumstances denial of Cashless Access should in no way be construed as denial of liability. The insured person may obtain the treatment as per his/her treating doctor's advice and later on submit the full claim papers to the TPA/Insurer within 15 days of the discharge from Hospital / Nursing Home for consideration of Company / TPA.

**iii)** Should any information be available to the Company / TPA which makes the claim inadmissible or doubtful, and warrants further investigations, the authorization of cashless facility may be withdrawn. However this shall be done by the Company / TPA before the patient is discharged from the Hospital and notice to this effect given to the treating hospital / insured.

**iv)** List of network hospitals is available on our official website- www.orientalinsurance.org.in and will also be provided by the concerned TPA.

**MEDICAL RECORDS:**

**(i)** The insured person hereby agrees to and authorizes the disclosure, to the Company / TPA or any other person nominated by the Company, of any and all Medical records and information held by any Institution / Hospital or Person from which the insured person has obtained any medical or other treatment to the extent reasonably required by the Company / TPA in connection with any claim made under this policy or the Company's liability there under.

**(ii)** The Company / TPA agree that they will preserve the confidentiality of any documentation and information that comes into their possession pursuant to (i) above and will only use it in connection with any claim made under this policy or the Company's liability there under.

**(iii)** Any medical practitioner authorized by the Company / TPA shall be allowed to examine the Insured Person in case of any alleged injury or disease requiring Hospitalization when and so often as the same may reasonably be required on behalf of the Company / TPA.

**PAYMENT OF CLAIM:** All medical treatment for the purpose of this insurance will have to be taken in India only and all claims shall be payable in Indian currency only.

**PROPORTIONATE CLAUSE -** If the Insured Person is admitted in the hospital in a room where the room category or the Room Rent incurred is higher than the eligibility as specified in the Policy Schedule/ Certificate of Insurance, then the Policyholder/ Insured Person shall bear a rateable proportion of the total & specified Associated Medical Expenses (including surcharge or taxes thereon) in the proportion of the difference between the Room Rent of the entitled room category/eligible Room Rent to
the Room Rent actually incurred. However, this will not be applicable in respect of Medicines/Pharmacy/ Drugs, Consumables, Medical Devices/ implants and Cost of Diagnostics.

**ASSOCIATED MEDICAL EXPENSES :**

· Doctor's fees / Consultant fees/RMO fees
· Nursing expenses including administration charges/ transfusion charges/ injection charges
· Surgeon fees / Asst Surgeon fees
· Anesthesia fees
· Procedure charges of any kind which includes :-

I) Chemotherapy/Radiotherapy charges
II) Nebulisation
III) Hemodialysis
IV) PICC line insertion
V) Catheterisation charges
VI) Tracheostomy etc.
VII) IV charges
VIII) Blood transfusion charges IX) Dialysis
IX) Surgery Charges
X) OT charges including OT gas, equipment charges

**SUBROGATION**: In the event of a claim paid under the policy, the Company shall assume the rights of the insured person to recover expenses paid out under the policy that may be recovered from any other source.

**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 rateable proportion of Sum Insured.

If two or more policies are taken by the insured during a period from one or more insurers, the contribution clause shall not be applicable where the cover/ benefit offered:

i. is fixed in nature:

ii. does not have any relation to the treatment costs;

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

**REPUDIATION:**

i. The Company, shall repudiate the claim if not payable under the policy. The Company / TPA shall mention the reasons for repudiation in writing to the insured person. The insured person shall have the right to appeal / approach the Grievance Redressal Cell of the company at its policy issuing office, concerned Divisional Office, concerned Regional Office or of the Head Office, situated at A-25/27, Asaf Ali Road, New Delhi-110002.

If the insured is not satisfied with the reply of the Grievance Cell under (i), he may approach the Insurance Ombudsman, established by the Central Government for redressal of grievance. The Insurance Ombudsman is empowered to adjudicate on personal lines of insurance claims up to Rs.30 lacs.

**GRIEVANCE REDRESSAL:**

In case of any grievance the insured person may contact the company through **Website:** www.orientalinsurance.org.in

**Toll free:** 1800118485 Or 011- 33208485

**E-mail:** csd@orientalinsurance.co.in

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:

**Customer Service Department 4th Floor, Agarwal House Asaf Ali Road,**

**New Delhi-110002.** For updated details of grievance officer, kindly refer the link https://orientalinsurance.org.in/documents/10182/7605007/List+of+Nodal+Officer+.pdf/992a7f9b-aef7-5cac- c613-ffc05d578a3e

**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 as Annexure-III & revised details of insurance ombudsman as and when amended as available in the website http://ecoi.co.in/ombudsman.html Grievance may also be lodged at IRDAI Integrated Grievance Management System – https://igms.irda.gov.in/

**DISCLAIMER OF CLAIM:** If the Company shall disclaim liability and communicates in writing (either through the TPA or by itself) to the Insured in respect of any claim hereunder and such claim has not within 12 calendar months from the date of such disclaimer been made the subject matter of a suit in a court of law, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

**ARBITRATION CLAUSE:** If any dispute or difference shall arise as to the quantum to be paid under 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 or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of 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.

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

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

**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, 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.

**CANCELLATION CLAUSE:**

**a).** The Insured may cancel this Policy by giving 15days' written notice, and in such an event, the Company shall refund premium on short term rates for the unexpired Policy Period as per the rates detailed below.

| **Period on Risk** | **Rate of premium to be charged** |
|---|---|
| Upto 1 Month | 1/4th of the annual rate |
| Upto 3 Months | 1/2 of the annual rate |

| | |
|---|---|
| Upto 6 Months | 3/4th of the annual rate |
| Exceeding 6 months | Full annual rate |

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.

**b).** The Company may cancel the Policy at any time on grounds of misrepresentation, non- disclosure of material facts fraud by the insured Person, by giving 30(thirty) days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation non- disclosure of material facts or fraud.

**FREE LOOK PERIOD:** The insured person is allowed free look period of fifteen days from the 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, and exercises this option, 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 Persons 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 on cover or

iii. where only a part of the risk has commenced, such proportionate risk premium commensurate with the risk covered during such period.

**GRACE PERIOD**: In the event of delay in renewal of the policy, a grace period of 30 days is allowed. However, no coverage shall be available during the grace period and any disease/injury contracted during the break period shall not be covered and shall be treated as Pre-existing disease.

**RENEWAL OF POLICY:** The policy shall ordinarily be renewable except on grounds of fraud, Misrepresentation by the insured person.

**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.** The Company shall not be responsible or liable for non-renewal of policy due to non-receipt or delayed receipt (i.e. After the due date) of the proposal form or of the medical practitioners report wherever required or due to any other reason whatsoever.

**IV**. Notwithstanding this, however, the decision to accept or reject for coverage any person upon renewal of this insurance shall rest solely with the Company. The company may at its discretion revise the premium rates and/or the terms & condition of the policy every year upon renewal thereof. Renewal of this policy is not automatic;

**V.** Premium due must be paid by the proposer to the company before the due date.

**VI**. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give notice for renewal.

**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.

**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 link:-
https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

**Portability:** The Insured Person will have the option to port the Policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.
For Detailed Guidelines on Portability, kindly refer the link:
https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

**MORATORIUM PERIOD**

After completion of eight continuous years under this 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 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 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.

**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. Ill 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

**CHANGE OF ADDRESS:** Insured must inform the Company immediately in writing of any change in the address.

**QUALITY OF TREATMENT:** The insured hereby acknowledges and agrees that pre-authorization or payment of any claim by or on behalf of the Company shall not constitute on part of the Company, a guarantee or assurance as to the quality or effectiveness of any medical treatment obtained by the insured person. It being agreed and recognized by the insured person that the Company is in no way responsible or liable for the availability or quality of any services (Medical or otherwise) rendered by any institution (including a network hospital).

**ID CARD:** The card is issued to the insured person by the TPA to avail cash less facility in the Network Hospital only. Upon the cancellation or non renewal of this policy, all ID cards shall immediately be returned to the TPA at the insured's expense and each insured person agrees to hold and keep harmless, the Company and the TPA against any or all costs, expenses, liabilities and claims arising in respect of use or misuse of such ID cards prior to their return to the TPA.

**JURISDICTION:** All disputes or differences under or in relation to the policy shall be determined by the Indian Courts and according to the Indian laws.

**IRDA REGULATION :** This Policy is subject to IRDAI (Protection of Policy holders' interest) Regulation, 2017 and IRDAI (Health Insurance) Regulations 2016 and Guidelines on Standardization in health insurance, as amended from time to time.

**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.

(**Explanation: "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 take informed decision in the context of underwriting the risk)**

**Appendix I Day care procedures / surgeries**

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|---|---|
| **A** | **Microsurgical Operations on the Middle Ear** |
| 1 | Stapedotomy |
| 2 | Stapedectomy |
| 3 | Revision of a stapedectomy |
| 4 | Myringoplasty (Type -I Tympanoplasty |
| 5 | Tympanoplasty (closure of an eardrum perforation/reconstruction of the auditory ossicles) |
| 6 | Revision of a tympanoplasty |
| **B** | **Other operations on the middle & internal ear** |
| 7 | Myringotomy |
| 8 | Removal of a tympanic drain |
| 9 | Incision of the mastoid process and middle ear |
| 10 | Mastoidectomy |
| 11 | Reconstruction of the middle ear |
| 12 | Fenestration of the inner ear |
| 13 | Revision of a fenestration of the inner ear |
| 14 | Incision (opening) and destruction (elimination) of the inner ear |
| **C** | **Operations on the nose & the nasal sinuses** |
| 15 | Excision and destruction of diseased tissue of the nose |
| 16 | Operations on the turbinates (nasal concha) |
| 17 | Nasal sinus aspiration |
| **D** | **Operations on the eyes** |
| 18 | Incision of tear glands |
| 19 | Incision of diseased eyelids |
| 20 | Excision and destruction of diseased tissue of the eyelid |
| 21 | Operations on the canthus and epicanthusv |
| 22 | Corrective surgery for entropion and ectropion |
| 23 | Corrective surgery for blepharoptosis |
| 24 | Removal of a foreign body from the conjunctiva |
| 25 | Removal of a foreign body from the cornea |
| 26 | Incision of the cornea |
| 27 | Operations for pterygium |

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| 28 | Removal of a foreign body from the lens of the eye |
| 29 | Removal of a foreign body from the posterior chamber of the eye |
| 30 | Removal of a foreign body from the orbit and eyeball |
| 31 | Operation of cataract |
| **E** | **Operations on the skin & subcutaneous tissues** |
| 32 | Incision of a pilonidal sinus |
| 33 | Free skin transplantation, donor site |
| 34 | Free skin transplantation, recipient site |
| 35 | Revision of skin plasty |
| 36 | Simple restoration of surface continuity of the skin and subcutaneous tissues |
| 37 | Destruction of diseased tissue in the skin and subcutaneous tissues |
| 38 | Local excision of diseased tissue of the skin and subcutaneous tissues |
| 39 | Surgical wound toilet (wound debridement) and removal of diseased tissue of the skin and subcutaneous tissues |
| 40 | Chemosurgery to the skin |
| **F** | **Operations on the tongue** |
| 41 | Incision, excision and destruction of diseased tissue of the tongue |
| 42 | Partial glossectomy |
| 43 | Glossectomy |
| 44 | Reconstruction of the tongue |
| **G** | **Operations on the salivary glands & salivary ducts** |
| 45 | Incision and lancing of a salivary gland and a salivary duct |
| 46 | Excision of diseased tissue of a salivary gland and a salivary duct |
| 47 | Resection of a salivary gland |
| 48 | Reconstruction of a salivary gland and a salivary duct |
| **H** | **Other operations on the mouth & face** |
| 49 | External incision and drainage in the region of the mouth, jaw and face |
| 50 | Incision of the hard and soft palate |
| 51 | Excision and destruction of diseased hard and soft palate |
| 52 | Incision, excision and destruction in the mouth |
| 53 | Plastic surgery to the floor of the mouth |
| 54 | Palatoplasty |
| **I** | **Operations on the tonsils & adenoids** |
| 55 | Transoral incision and drainage of a pharyngeal abscess |
| 56 | Tonsillectomy without adenoidectomy |
| 57 | Tonsillectomy with adenoidectomy |
| 58 | Excision and destruction of a lingual tonsil |
| **J** | **Trauma surgery and orthopaedics** |
| 59 | Incision on bone, septic and aseptic |

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| 60 | Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis |
| 61 | Reduction of dislocation under GA |
| 62 | Arthroscopic knee aspiration |
| **K** | **Operations on the breast** |
| 63 | Incision of the breast |
| 64 | Operations on the nipple |
| **L** | **Operations on the digestive tract** |
| 65 | Incision and excision of tissue in the perianal region |
| 66 | Surgical treatment of anal fistulas |
| 67 | Surgical treatment of haemorrhoids |
| 68 | Division of the anal sphincter (sphincterotomy) |
| 69 | Ultrasound guided aspirations |
| 70 | sclerotherapy |
| **M** | **Operations on the female sexual organs** |
| 71 | Incision of the ovary |
| 72 | Insufflation of the Fallopian tubes |
| 73 | Dilatation of the cervical canal |
| 74 | Conisation of the uterine cervix |
| 75 | Incision of the uterus (hysterotomy) |
| 76 | Therapeutic curettage |
| 77 | Culdotomy |
| 78 | Incision of the vagina |
| 79 | Local excision and destruction of diseased tissue of the vagina and the pouch of Douglas |
| 80 | Incision of the vulva |
| 81 | Operations on Bartholin's glands (cyst) |
| **N** | **Operations on the prostate & seminal vesicles** |
| 82 | Incision of the prostate |
| 83 | Transurethral excision and destruction of prostate tissue |
| 84 | Transurethral and percutaneous destruction of prostate tissue |
| 85 | Open surgical excision and destruction of prostate tissue |
| 86 | Radical prostatovesiculectomy |
| 87 | Incision and excision of periprostatic tissue |
| 88 | Operations on seminal vesicles |
| **O** | **Operations on the scrotum & tunica vaginalis testis** |
| 89 | Incision of the scrotum and tunica vaginalis testis |
| 90 | Operation on a testicular hydrocele |
| 91 | Excision and destruction of diseased scrotal tissue |
| 92 | Plastic reconstruction of the scrotum and tunica vaginalis testis |

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| **P** | **Operations on the testes** |
| 93 | Incision of the testes |
| 94 | Excision and destruction of diseased tissue of the testes |
| 95 | Unilateral orchidectomy |
| 96 | Bilateral orchidectomy |
| 97 | Orchidopexy |
| 98 | Abdominal exploration in cryptorchidism |
| 99 | Surgical repositioning of an abdominal testis |
| 100 | Reconstruction of the testis |
| 101 | Implantation, exchange and removal of a testicular prosthesis |
| **Q** | **Operations on the spermatic cord, epididymis und ductus deferens** |
| 102 | Surgical treatment of a varicocele and a hydrocele of the spermatic Cord |
| 103 | Excision in the area of the epididymis |
| 104 | Epididymectomy |
| 105 | Reconstruction of the spermatic cord |
| 106 | Reconstruction of the ductus deferens and epididymis |
| **R** | **Operations on the penis** |
| 107 | Operations on the foreskin |
| 108 | Local excision and destruction of diseased tissue of the penis |
| 109 | Amputation of the penis |
| 110 | Plastic reconstruction of the penis |
| **S** | **Operations on the urinary system** |
| 111 | Cystoscopical removal of stones |
| **T** | **Other Operations** |
| 112 | Lithotripsy |
| 113 | Coronary angiography |
| 114 | Haemodialysis |
| 115 | Radiotherapy for Cancer |
| 116 | Cancer Chemotherapy |

**Annexure I**

**List I- Items for which coverage is not available in the policy**

| Sl. No. | Item |
|---|---|
| 1 | BABY FOOD |
| 2 | BABY UTILITIES |
| 3 | BEAUTY SERVICES |
| 4 | BELTS/BRACES |
| 5 | BUDS |
| 6 | COLD PACK/HOT PACK |

| | |
|---|---|
| 7 | CARRY BAGS |
| 8 | EMAIL/ INTERNET CHARGES |
| 9 | FOOD CHARGES (OTHER THAT PATIENT'S DIET PROVIDED BY HOSPITAL) |
| 10 | LEGGINGS |
| 11 | LAUNDRY CHARGES |
| 12 | MINERAL WATER |
| 13 | SANITARY PAD |
| 14 | TELEPHONE CHARGES |
| 15 | GUEST SERVICES |
| 16 | CREPE BANDAGE |
| 17 | DIAPER OF ANY TYPE |
| 18 | EYELET COLLAR |
| 19 | SLINGS |
| 20 | BLOOD GROUPING ND CROSS MATCHING OF DONORS SAMPLES |
| 21 | SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED |
| 22 | TELEVISION CHARGES |
| 23 | SURCHARGES |
| 24 | ATTENDANT CHARGES |
| 25 | EXTRA DIET OF PATIENT (other that which forms part of bed charges) |
| 26 | BIRTH CETIFICATE |
| 27 | CETIFICATE CHARGES |
| 28 | COURIER CHARGES |
| 29 | CONVEYANCE CHARGES |
| 30 | MEDICAL CRTIFICATE |
| 31 | MEDICAL RECORDS |
| 32 | PHOTOCOPY CHARGES |
| 33 | MORTUARY CHARGES |
| 34 | WALKING AIDS CHARGES |
| 35 | OXYGEN CYLINDER ( FOR USAGE OUTSIDE THE HOSPITAL) |
| 36 | SPACER |
| 37 | SPIROMETER |
| 38 | NEBULIZER KIT |
| 39 | STEAM INHALER |
| 40 | ARMSLING |
| 41 | THERMOMETER |
| 42 | CERVICAL COLLAR |
| 43 | SPLINT |

| | |
|---|---|
| 44 | DIABETIC FOOT WEAR |
| 45 | KNEE BRACES (LONG/SHORT/HINGED) |
| 46 | KNEE IMMOBOLOZER/SHOULDER IMMOBOLIZER |
| 47 | LUMBO SCARLET BELT |
| 48 | NIMBUS BED OR WATER OR AIR BED CHARGES |
| 49 | AMBULANCE COLLAR |
| 50 | AMBULANCE EQUIPMENT |
| 51 | ABDOMINAL BINDER |
| 52 | PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES |
| 53 | SUGAR FREE TABLETS |
| 54 | CREAMS, POWDERS, LOTIONS ( Toiletries are not payable, only prescribed medical pharmaceuticals payable) |
| 55 | ECG ELECTRODES |
| 56 | GLOVES |
| 57 | NEBULISATION KIT |
| 58 | ANY KIT WITH NO DETAILS MENTIONED (DELIVERY KIT, ORTHOKIT, RECOVERY KIT ETC.) |
| 59 | KIDNEY TRAY |
| 60 | MASK |
| 61 | OUNCE GLASS |
| 62 | OXYGEN MASK |
| 63 | PELVIC TRACTION BELT |
| 64 | PAN CAN |
| 65 | TROLLY COVER |
| 66 | UROMETER, URINE JUG |
| 67 | AMBULANCE |
| 68 | VASOFIX SAFETY |

| **List II- Items that are to be subsumed into Room Charges** | |
|---|---|
| **Sl. No** | **ITEMS** |
| 1 | BABY CHARGES (UNLESS SPECIFIED/INDICATED) |
| 2 | HAND WASH |
| 3 | SHOE COVER |
| 4 | CAPS |
| 5 | CRADLE CHARGES |
| 6 | COMB |
| 7 | EAU-DE-COLOGNE/ROOM FRESHNERS |
| 8 | FOOT COVER |
| 11 | TISSUE PAPER |

| | |
|---|---|
| 12 | TOOTH PASTE |
| 13 | TOOTH BRUSH |
| 14 | BED PAN |
| 15 | FACE MASK |
| 16 | FLEXI MASK |
| 17 | HAND HOLDER |
| 18 | SPUTUM CUP |
| 19 | DISINFECTANT LOTIONS |
| 20 | LUXURY TAX |
| 21 | HVAC |
| 22 | HOUSE KEEPING CHARGES |
| 23 | AIR CONDITIONER CHARGES |
| 24 | IM IV INJECTION CHARGES |
| 25 | CLEAN SHEET |
| 26 | BLANKET/ WARMER BLANKET |
| 27 | ADMISSION KIT |
| 28 | DIABETIC CHART CHARGES |
| 29 | DOCUMENTATION CHARGES/ADMINISTRATIVE CHARGES |
| 30 | DISCHARGE PROCEDURE CHARGES |
| 31 | DAILY CHART CHARGES |
| 32 | ENTRANCE PASS/ VISITORS PASS CHARGES |
| 33 | EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE |
| 34 | FILE OPENING CHARGES |
| 35 | INCIDENTAL EXPENSES/MISC. CHARGES (NOT EXPLAINED) |
| 36 | PATIENT IDENTIFICATION BAND /NAME TAG |
| 37 | PULSWOXYMETER CHARGES |

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

| Sl. No. | Items |
|---|---|
| 1 | HAIR REMOVAL CREAM |
| 2 | DISPOSABLE RAZORS CHARGES ( FOR SITE PREPARATION) |
| 3 | EYE PAD |
| 4 | EYE SHIELD |
| 5 | CAMERA COVER |
| 6 | DVD, CD CHARGES |
| 7 | GAUZE SOFT |
| 8 | GAUZE |
| 9 | WARD AND THEATRE BOOKING CHARGES |

| | |
|---|---|
| 10 | ARTHROSCOPYAND ENDOSCOPY INSTRUMENTS |
| 11 | MICROSCOPIC COVER |
| 12 | SURGICAL BLADES, HORMONICSCALPEL,SHAVER |
| 13 | SURGICAL DRILL |
| 14 | EYE KIT |
| 15 | EYE DRAPE |
| 16 | X-RAY FILM |
| 17 | BOYLES APPRATUS CHARGES |
| 18 | COTTON |
| 19 | COTTON BANDAGE |
| 20 | SURGICAL TAPE |
| 21 | APRON |
| 22 | TORNIQUET |
| 23 | ORTHO BUNDLE, GYNAE BUNDLE |

**Section II**: Coverage for earning Head of the family as declared in the schedule

A. If the Insured Person (earning head of the family) shall sustain any bodily injury resulting solely and directly from Accident caused by outward, violent and visible means, and if such injury shall within 6 calendar months (unless otherwise specified) of its occurrence lead to death then the Company shall pay to the Insured a sum of Rs. 25,000/-

B. If the earning head of the family is hospitalised due to accident/ disease/ illness for which there is a valid claim admitted under section 1 of the policy then after a waiting period of 3 days the company shall pay to the earning head of the family a compensation of Rs. 50/- per day from the 4$^{th}$ day of hospitalisation upto a maximum of 15 days per policy period.

## Exclusions

Death injury or disablements arising directly or indirectly from or traceable to:

i. Intentional self injury, suicide or attempted suicide
ii. Pregnancy or in consequence thereof
iii. Whilst engaging in aviation or Ballooning, whilst mounting into dismounting from or travelling in any Balloon or aircraft other than as a passenger (fare paying or otherwise) in any duly licensed standard type of aircraft anywhere in the world.
iv. Whilst under the influence of intoxication, liquor or drugs
v. Directly or indirectly caused by venereal diseases or insanity
vi. Arising or resulting from the insured committing any breach of law with criminal intent
vii. War and war like perils, nuclear perils, radioactivity etc.

**CONDITIONS APPLICABLE TO SECTIONS – I & II:**

1. Every notice or communication to be given or made under this Policy shall be delivered in writing at the address of the TPA/ insurer office as shown in the Schedule.
2. The premium payable under this Policy shall be paid in advance.
3. No receipt for Premium shall be valid except on the official form of the company signed by a duly authorised official of the company. The due payment of premium and the observance and fulfilment of the terms, provisions, conditions and endorsements of this Policy by the Insured Person in so far as they relate to

anything to be done or complied with by the Insured Person shall be a condition precedent to any liability of the Company to make any payment under this Policy. No waiver of any terms, provisions, conditions and endorsements of this policy shall be valid unless made in writing and signed by an authorised official of the Company.

4. Upon the happening of any event which may give rise to a claim under this Policy notice with full particulars shall be sent to the TPA/ insurer named in the schedule immediately and in case of emergency within 24 hours of Hospitalisation.
5. All supporting documents relating to the claim must be filed with TPA/ insurer within 7 days from the date of discharge from the hospital.
   Note: Waiver of this Condition may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time-limit.
6. The Insured Person shall obtain and furnish the TPA/ insurer with all original bills, receipts and other documents upon which a claim is based and shall also give the TPA/ insurer such additional information and assistance as the TPA/insurer may require in dealing with the claim.
7. In case of death of earning member of the family due to accident a post-mortem report must be submitted along with other documents of proof of death.
8. Any medical practitioner authorised by the TPA / insurer shall be allowed to examine the Insured Person in case of any alleged injury or disease requiring Hospitalisation when and so often as the same may reasonably be required on behalf of the Company.
9. The Company shall not be liable to make any payment under this policy in respect of any claim if such claim be in any manner fraudulent or supported by any fraudulent means or device whether by the Insured Person or by any other person acting on his behalf.
10. If at the time when any claim arises under this Policy, there is in existence any other insurance (other than Cancer Insurance Policy in collaboration with Indian Cancer Society), whether it be effected by or on behalf of any Insured Person in respect of whom the claim may have arisen covering the same loss, liability, compensation, costs or expenses, the Company shall not be liable to pay or contribute more than its rateable proportion of any loss, liability, compensation costs or expenses. The benefits under this Policy shall be in excess of the benefits available under Cancer Insurance Policy.
11. The policy may be renewed by mutual consent. The Company shall not however be bound to give notice that it is due for renewal. The Company may at any time cancel the Policy on grounds of misrepresentation, fraud, non-disclosure of material fact or non-cooperation by the insured by sending seven days notice in writing by Registered A/D to the insured at his last known address in which case the Company shall return to the insured a proportion of the last premium corresponding to the unexpired period of insurance if no claim has been paid under the policy. The insured may at any time cancel this policy and in such event the Company shall allow refund of premium at Company's short period rate table given below provided no claim has occurred upto the date of cancellation.

| PERIOD ON RISK | RATE OF PREMIUM TO BE CHARGED. |
|---|---|
| Upto one month | 1/4 th of the annual rate |
| Upto three months | 1/2 of the annual rate |
| Upto six months | 3/4$^{th}$ of the annual rate |
| Exceeding six months | Full annual rate.. |

12. It will be the right of the insurer to assume the rights of the insured person to recover expenses paid out under the policy that may be recovered from any other source.
13. It will be the right of the insurer to call upon other insurer, laible to the same insured to share the cost of an indemnity claim on a ratable proportion.
14. If any dispute or difference shall arise as to the quantum to be paid under 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 or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of 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.

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

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

15. If the TPA/ Company, shall disclaim liability to the Insured for any claim hereunder and if the Insured shall not within 12 calendar months from the date or receipt of the notice of such disclaimer notify the Company in writing that he does not accept such disclaimer and intends to recover his claim from the Company then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.
16. All medical/surgical treatments under this policy shall have to be taken in India and admissible claims thereof shall be payable in Indian currency.
17. Grace period of 15days will be available 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 period. Coverage is not available for the period for which no premium is received.
18. Renewal of a contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose
19. IRDA Regulation no. 5. This policy is subject to Regulation 5 of IRDA (Protection of Policy Holder Interest) Regulation.

**Claims Minimization Clause (Section-I & II)**

The Insured will at all times cooperate with a Company/TPA to contain claims ratio by ensuring that the treatment charges and other expenses are reasonable and necessary and will be subject to further sub-limits as may be required.

**Premium adjustment clause**

If the claim ratio exceeds 80% of the premium paid the renewal rate will be adjusted so as to ensure that the claims ratio remains within 80% of the premium paid. For arriving at the claims ration, the first ten months will be taken into consideration and an average of the whole year will be taken and premium charges provisionally. The final adjustment if any will be made at the end of 60days in the new policy period after full incurred claims figures are available. In subsequent years the claim ration will be taken on the average of 2 or 3 years as the case may be.

## IMPORTANT

### Free Look Period

This Policy shall have a free look period. The free look period shall be applicable at the inception of the policy and:

1. The insured will be allowed a period of at least 15 days from the date of receipt of the policy to review the terms and conditions of the policy and to return the same if not acceptable
2. If the insured has not made any claim during the free look period, the insured shall be entitled to
   - **a.** A refund of the premium paid less any expenses incurred by the insurer on medical examination of the insured persons and the stamp duty charges or;
   - **b.** where the risk has already commenced and the option of return of the policy is exercised by the policyholder, a deduction towards the proportionate risk premium for period on cover or;
   - **c.** Where only a part of the risk has commenced, such proportionate risk premium commensurate with the risk covered during such period.