CIN No. U66010RJ2006PLC029979
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Shriram General insurance Co. Ltd.

IN PARTNERSHIP WITH THE **Sanlam** GROUP
Regd.&Corpt. Office:E-8, EPIP, RIICO Industrial Area, Sitapura, Jaipur (Rajasthan) – 302022
Phone: +91-141-3928400, 3951111, Fax: +91-141-2770692, 2770693
Website: www.shriramgi.com, E-mail: customer.feedback@shriramgi.in
Toll Free: 1800-103-3009, 1800-300-30000, ISO/IEC 27001:2013 certified

Shri Sarv-Care Health Benefit Package Policy – Policy Wording

1. PREAMBLE

SHRIRAM General Insurance Company Limited (We, Our or Us) will provide the insurance described in this Policy and any endorsements thereto for the Insured Period as defined in this Policy, to the Insured Persons detailed in the Policy Schedule and in reliance upon the statements contained in the Proposal and Declaration Form filled and signed by the Policyholder, which shall be the basis of this Policy and are deemed to be incorporated herein in return for the payment of the required premium when due and compliance with all applicable provisions of this Policy.
The insurance provided under this Policy is only with respect to such and so many of the benefits as are indicated by a specific amount set opposite in the Policy Schedule.

2. DEFINITIONS

The terms defined below and at other junctures in the Policy have the meanings ascribed to them wherever they appear in this Policy and, where, the context so requires, references to the singular include references to the plural; references to the male includes the female and references to any statutory enactment includes subsequent changes to the same.

2.1 **We, Us, Our/Ours** means the Shriram General Insurance Company Limited.

2.2 **You, Your, Yourself /Your family means** the Insured Person shown in the Schedule.

2.3 **Age** means age of the Insured person on last birthday as on date of commencement of the Policy.

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

2.5 **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\

2.6 **AYUSH Treatment** refers to hospitalization treatments given Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy systems.

2.7 **An AYUSH Hospital** is a healthcare facility wherein medical/surgical/para-surgical treatment and procedure carried out by AYUSH Medical Practitioner(s) comprising of any of the following.

a. Central and State Government AYUSH Hospital, or
b. Teaching hospitals attached to AYUSH Colleges recognized by Central Government/Council of Indian Medicine/Central Council of Homeopathy, or
c. AYUSH Hospitals standalone or co-locted with in-patient healthcare facility of recognized system of medicine, registered with local authority where applicable, and is under the supervision of qualified registered AYUSH Medical Practitioner and must comply with all the following creation:
   i. Having at least 5 in-patient beds
   ii. Having qualified AYUSH Medical Practitioner in charge round the clock
   iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theater where operation procedure are to be carried out.
   iv. Maintains daily records of patients and makes these accessible to the Company's authorized representative.

2.8 **AYUSH Day Care Centre** means and include Community Health Center(CHC), Primary Health Center(PHC), Dispensary, Clinic, Policlinic or any such health center which is registered with local authorities where applicable and having facility for carrying out treatment procedure and medical or

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surgical/para- surgical interventions or both the supervision of registered AYUSH Medical Practitioner(s) on day care basis without in-patient service must comply with all the following criterion.

i. Having qualified AYUSH Medical Practitioner in charge round the clock
ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theater where operation procedure are to be carried out .
iii. Maintains daily records of patients and makes these accessible to the Insurance Company's authorized representative.

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

2.10 **Condition Precedent** means a Policy term or condition upon which the Company's liability under the Policy is conditional upon.

2.11 **Congenital Anomaly means** 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.

2.12 **Critical illness** Means an illness, sickness or a disease or a corrective measure as specified in this Policy.

2.13 **Critical illness benefit** Means the amount specified in the Schedule, which is the maximum amount for which the Company may be liable to make payment for any Critical Illness.

2.14 **Day** means a continuous period of 24 hours.

2.15 **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.

2.16 **Day Care Treatment** means 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 hospitalization of more than 24 hours.
iii. Treatment normally taken on an out-patient basis is not included in the scope of this definition.

2.17 **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.

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

2.19 **Dependent Child** refers to a child (natural or legally adopted), who is financially dependent on the primary insured or proposer and does not have his / her independent sources of income.

2.20 **Disclosure to information norm:** The policy shall be void and all premiums paid thereon shall be forfeited to the Insurer in the event of misrepresentation, mis-description or non-disclosure of any material fact.

2.21 **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.

2.22 **Family** means, the Family that consists of the proposer and any one or more of the family members as mentioned below:

- Self
- Spouse
- Children (including unmarried children, step children or legally adopted children, who are financially dependent and aged between 91 days and 25 years).
- Parents or and parents-in-law

2.23 **Grace Period:** means specified period of time immediately following the premium due date during which a payment can be made to renew or continue the Policy in force without loss of continuity benefits such as waiting period and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

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

i. Has qualified nursing staff under its employment round the clock;
ii. Has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and 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 shall make these accessible to the Company's authorized personnel.

2.25 **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.

2.26 **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

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2.27 **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.

2.28 **In-Patient Care** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

2.29 **Insured Person** means person(s) named in the schedule of the Policy.

2.30 **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.

2.31 **Maternity expenses mean**

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.

2.32 **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow up prescription.

2.33 **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 license.

Note – The registered practitioner should not be the insured or close member of the family

2.34 **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 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.

2.35 **Migration** means**,** the right accord to health insurance policyholder (including all the member 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.

2.36 **Named insured/ insured** means the persons and or his Family members, named in the Schedule.

2.37 **Nominee** means a person designated by You to receive the proceeds of this Policy upon Your death.

2.38 **Notification of Claim** means the process of intimating a claim to the Insurer or TPA through any of the recognized modes of communication.

2.39 **Out-Patient (OPD) Treatment** means treatment 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.

2.40 **Pre-Existing Disease (PED)**
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 or its reinstatement.

2.41 **Policy** means these Policy wordings, the Policy Schedule 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.

2.42 **Policy period/ Policy tenure** mean period as mentioned in the schedule for which the Policy is issued

2.43 **Policy Schedule** means the Policy Schedule attached to and forming part of Policy.

2.44 **Policy year mea**ns a period of twelve months beginning from the date of commencement of the policy period and ending on the last day of such twelve month period. For the purpose of subsequent years, policy year shall mean a period of twelve months commencing from the end of the previous policy year and lapsing on the last day of such twelve-month period, till the policy period, as mentioned in the schedule

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

2.46 **Proposal form** means a form to be filled in by the prospect in written or electronic or any other format as approved by the Authority, for furnishing all material information as required by the insurer in respect of a risk, in order to enable the insurer to take informed decision in the context of underwriting the risk, and in the event of acceptance of the risk, to determine the rates, advantages, terms and conditions of the cover to be granted.

2.47 **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.

2.48 **Renewal:** 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.

2.49 **Sum Insured** means the amount specified in the Policy Schedule, which We will pay for claims made by You under the Policy Year in respect of the Insured Person(s).

2.50 **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 of suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner

2.51 **Schedule** means the schedule and any annexure to it

2.52 **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.

2.53 **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.

3. SCOPE OF COVERAGE

Section I :Shri Hospital Daily Cash Benefit Insurance

The Company hereby agrees to pay in respect of an admissible claim, any or all of the following covers subject to the Sum Insured, limits, terms, conditions and definitions, exclusions contained or otherwise expressed in this Policy.'

1. COVER DETAILS

Basic Plan

I. Sickness Daily Hospital Cash Benefit

During the period stated in the Schedule, if the insured person shall contract any disease or suffer from any illness and if such disease / illness shall, upon the advice of a duly Qualified Medical Practitioner, require admission of the insured Person as an In-patient in any Hospital in India for the purpose of medical /surgical treatment, then the Company will pay to the Insured Person, Daily Hospital Cash amount mentioned in the schedule for each consecutive 24 hours of hospitalization subject to maximum number of days stated in the Schedule.

Deductible - 1- day deductible is applicable on every hospitalization.

II. Accident Hospital Cash Benefit

During the period stated in the Schedule, if the insured person shall sustain bodily injury due to accident and if such accident shall, upon the advice of a duly Qualified Medical Practitioner, require admission of the insured Person as an In-patient in any Hospital in India for the purpose of medical /surgical treatment, then the Company will pay to the Insured Person, 2 times of Daily Hospital Cash amount mentioned in the schedule for each consecutive 24 hours of hospitalization subject to maximum number of days stated in the Schedule.

Deductible - Not Applicable

III. Intensive Care Unit (ICU) Benefit

During the policy period stated in the schedule If the insured person shall, upon the advice of a duly Qualified Medical Practitioner, require admission in ICU for the purpose of treatment of Sickness/Accident /Injury, then We will pay 2.5 times of the Daily Hospital Cash amount for each consecutive 24 hours that the Insured Person is admitted in an Intensive Care Unit, subject to maximum of 15 days per Policy Year. Whenever Intensive Care Unit benefit is admissible under the Policy, We will not pay for Daily Hospital Cash benefit in I or II above for the period when the Insured Person is in Intensive Care Unit.

Deductible - 1- day deductible is applicable on every hospitalization except accidental hospitalization.

Advance Plan

This is an addition to basic plan as specified above

I. Convalescence Benefit:
If the Insured Person is Hospitalized in India during the Policy Period for Medically Necessary treatment of an Illness Or an Injury that occurred during the Policy Period and the continuation of such Hospitalization is Medically Necessary for at least 15 consecutive days, then will pay a lump sum amount equal to 5 times of the Daily Cash Benefit amount specified in the Policy Schedule.

This benefit is payable in addition to basic plan only if there is an admissible claim under same.

For Individual Policy: This benefit is available only once during the Policy tenure for per Insured Person.

Deductible - Not Applicable

II. Child Birth Hospital Cash

During the period stated in the Schedule the insured person shall, upon the advice of a duly Qualified Medical Practitioner, require admission of the Insured Person as an In-patient in any Hospital in India for the purpose of Child Delivery, then the Company will pay to the insured person Daily Hospital Cash amount stated in the schedule subject to maximum number of days stated in the schedule.

Special Condition:

1. The benefit under this cover is payable after waiting period of 2 years from date of addition of spouse in the policy period subject to both self and spouse are covered.
2. This cover is available for maximum of 2 child for life time.

Deductible - Not Applicable

III. Compassionate Benefit

If the Insured Person is Hospitalized during the Policy Period for Medically Necessary treatment of an Injury due to an Accident that occurred during the Policy Period and the Insured Person dies during the course of such Hospitalization, We will pay the Nominee a lump sum amount equal to 10 times of the Daily Hospital Cash Benefit amount specified in the Policy Schedule.

This benefit is payable in addition to basic plan 4.1 only if there is an admissible claim under same.

Deductible - Not Applicable

Optional Cover

Day Care Treatment Benefit
If the Insured Person requires and avails a Medically Necessary Day Care Treatment (as defined under Annexure I below) during the Policy Period, We will pay a lump sum benefit amount which is the lower of 5 times the Daily Cash Benefit specified in the Policy Schedule or Rs.25,000 to the Insured Person for such Day Care Treatment provided the Insured Person is admitted in the Hospital for less than 24 hours.
The benefit under this Section shall be available for a maximum of 1 Day Care Treatments per Policy Year. In case of Cataract, coverage is limited to 1 surgery in a Policy year.

2.Exclusion

2.1 Specific Exclusion - Waiting Period Applicable To Basic Plan And Advance Plan

We shall not be liable to make any payment under this Policy directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following waiting periods. All the waiting periods shall be applicable individually for each Insured Person and claims shall be assessed accordingly.

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

i. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with insurer.
ii. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
iii. 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
iv. 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.

2. Specified disease/procedure waiting period - Two Years Exclusions (Code -Excl 02)

a. Expenses related to the treatment of the below listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

f. List of specific disease/procedures -
   i. Cataract,
   ii. Hysterectomy for Menorrhagia or Fibromyoma or prolapse of Uterus unless necessitated by malignancy myomectomy for fibroids,
   iii. Knee Replacement Surgery (other than caused by an Accident), Non-infectious Arthritis, Gout, Rheumatism, Osteoarthritis and Osteoporosis, Joint Replacement Surgery (other than caused by Accident), Prolapse of Inter-vertebral discs(other than caused by Accident), all Vertebrae Disorders, including but not limited to Spondylitis, Spondylolisthesis,
   iv. Varicose Veins and Varicose Ulcers,
   v. Stones in the urinary uro-genital and biliary systems including calculus diseases,
   vi. Benign Prostate Hypertrophy, all types of Hydrocele, Congenital Internal Anomaly,
   vii. Fissure, Fistula in anus, Piles, all types of Hernia, Pilonidal sinus, Haemorrhoids and any abscess related to the anal region,
   viii. Chronic Suppurative Otitis Media (CSOM), Deviated Nasal Septum, Sinusitis and related disorders, Surgery on tonsils/Adenoids, Tympanoplasty and any other benign ear, nose and throat disorder or surgery.
   ix. Gastric and Duodenal ulcer, any type of Cysts/ Nodules/ Polyps/ internal tumours/ skin tumours, and any type of Breast lumps(unless malignant), Polycystic Ovarian Diseases,
   x. Any surgery of the genito-urinary system unless necessitated by malignancy.

3. First 30 Days Waiting Period (Code - Excl 03)

i. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
ii. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
iii. The within referred waiting period shall be applicable to the enhanced sum insured in the event of granting higher sum insured subsequently

2.2 General Exclusion [Applicable for Basic and Advance Plan]

The Company shall not be liable for Hospital Cash Amount under this policy if the hospitalization is directly or indirectly for

1. **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.

2. **Rest Cure, rehabilitation and respite care- (Code- Excl 05)**
   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.

3. **Obesity/ Weight Control (Code- Excl 06)**
   Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
   1. Surgery to be conducted is upon the advice of the Doctor
   2. The surgery/Procedure conducted should be supported by clinical protocols
   3. The member has to be 18 years of age or older and
   4. Body Mass Index (BMI);
      a. greater than or equal to 40 or
      b. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
      i. Obesity-related cardiomyopathy
      ii. Coronary heart disease
      iii. Severe Sleep Apnea
      iv. Uncontrolled Type2 Diabetes

4. **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 sex.

5. **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, 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.

6. **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.

7. **Breach of law: (Code- Excl 10)**
   Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

8. **Excluded Providers (Code – Excl 11) -**
Expenses incurred towards treatment in any hospital or by an 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.

9. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code- Excl 12)**

10. 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 – Excl 13)**

11. 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-Excl 14**)

12. **Refractive Error (Code – Excl 15) -**
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres

13. **Unproven Treatments (Code – Excl 16) -**
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.

14. **Sterility and Infertility: (Code- Excl 17)**
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. Gestational Surrogacy
   iv. Reversal of sterilization

15. **Maternity: (Code -Excl 18)**

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

16. Intentional self-injury
17. Circumcision, Preputioplasty, Frenuloplasty, Preputial Dilatation and Removal of SMEGMA
18. Congenital External Condition / Defects / Anomalies
19. Venereal Disease and Sexually Transmitted Diseases (other than HIV)
20. Injury/disease directly or indirectly caused by or arising from or attributable to war, terrorism, invasion, act of foreign enemy, warlike operations (whether war be declared or not)

21. Injury or disease directly or indirectly caused by or contributed to by nuclear weapons/materials.

22. High Intensity Focused Ultra Sound, Uterine Fibroid Embolisation, Balloon Sinoplasty,Enhanced External Counter Pulsation Therapy and related therapies, Chelation therapy, Deep Brain Stimulation, Hyperbaric Oxygen Therapy, Rotational Field Quantum Magnetic Resonance Therapy, VAX-D, Low level laser therapy, Photodynamic therapy and such other therapies similar to those mentioned herein under this exclusion.

23. Stem cell Therapy, Chondrocyte Implantation, Procedures using Platelet Rich plasma and Intra articular

injection therapy.

24. Oral Chemotherapy, Immuno therapy and Biologicals, except when administered as an inpatient, when clinically indicated and hospitalization warranted.

25. Inoculation or Vaccination (except for post–bite treatment and for medical treatment for therapeutic reasons.

26. Dental treatment or surgery unless necessitated due to accidental injuries and requiring hospitalization. (Dentalimplants are not payable).

27. Medical and / or surgical treatment of Sleep apnea.

28. Cochlear implants and procedure related hospitalization expenses.

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

3.Condition

1. The premium payable under this policy shall be payable in advance. No receipt of 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 of fulfillment of the terms, provision, conditions and endorsements of this policy by the Insured Person/s, in so far as they relate to anything to be done or complied with by the Insured Person/s, 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 authorized official of the Company.

2. **Modification of the terms of the policy**
   The Company reserves the right to modify the policy terms and conditions or modify the premium of the policy with the prior approval of the Competent Authority. In such an event the insured will be intimated three months in advance.

3. **Withdrawal of the policy**
   i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.
   ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. as per IRDAI guidelines, provided the policy has been maintained without a break.

4. **Free Look Period**
   At the time of inception of the policy, the Insured will be allowed a period of 15 days from the date of receipt of the policy to review the terms and conditions of the policy and to return the policy if not acceptable. In such a case, the premium refund shall be as follows
   If the Insured has not made any claim during the free look period, the Insured shall be entitled to –
   a. A refund of the premium paid less any expenses incurred by the Insurer on medical examination of the insured persons and the stamp duty charges and any policy administrative charges or
   b. Where the risk has already commenced and the option of return of the policy is exercised by the policy holder, a deduction towards the proportionate risk premium for period on cover or
   c. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.
   d. Free look period shall not be applicable at the time of renewal.

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5. **Disclosure to information norms**
   The policy shall become void and all premium paid hereon shall be forfeited to the Company, in the event of nondisclosure of any material fact and/or misrepresentation, fraud, moral hazard, misdescription as declared in the proposal form and/or claim form at the time of claim.
6. **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/Circulars_List.aspx?mid=3.2.3

7. **Migration**
   The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying formigration of the policy atleast 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/Circulars_List.aspx?mid=3.2.3

8. **Policy Termination**:
   The insurance under this policy with respect to each relevant Insured Person shall expire immediately on the earlier of the following events:
   a. Upon the death of the Insured Person.
   b. Upon exhaustion of the Hospital Cash amount chosen.
   c. Upon exhaustion of the Maximum number of days per year chosen.

9. **Renewal**:
   The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.
   i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
   ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
   iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
   iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
   v. No loading shall apply on renewals based on individual claims experience.

10. **Important Note**
    Where the policy is issued for more than 1 year, the benefits under the policy is for each of the year, without any carry over benefit thereof.

11. **Policy disputes**
    Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein is understood and agreed to by both the Insured and the Company to be subject to Indian Law.

12. **Notices**
    Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand,

post, or facsimile/email to E-8, EPIP, RIICO Industrial Area, Sitapura, Jaipur (Rajasthan) – 302022 Phone: +91-141-3928400, 3951111, Fax: +91-141-2770692, 2770693 Website: www.shriramgi.com, E-mail: customer.feedback@shriramgi.in. Notice and instructions will be deemed served 7 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

13. **Customer Service**

If at any time the Insured Person requires any clarification or assistance, the insured may contact the offices of the Company at the address specified, during normal business hours.

14. **Cancellation**

We may at any time cancel the Policy on grounds of misrepresentation, fraud, non-disclosure of material fact by sending written notice to the insured at his/her last known address at least 15 days in advance in that case we shall refund pro-rata premium for the unexpired portion of the policy on the date of cancellation, provided no claim has occurred till the date of cancellation.

The Insured may also give 15 days' notice in writing, to the Company, for the cancellation of this policy, in which case the Company shall retain the premium for the period this Policy has been in force at the Company's short period scales.

Period on risk	**% of Annual Premium refunded**		
	1 Year Policy	2 Year Policy	3 Year Policy
Upto 1 month	**70%**	**75%**	**80%**
Exceeding 1 month and upto 3 months	55%	70%	70%
Exceeding 3 months and upto 6 months	30%	55%	65%
Exceeding 6 months and upto 12 months	Nil	30%	45%
Exceeding 12 months and upto 18 months		10%	30%
Exceeding 18 months and upto 24 months		Nil	10%
Exceeding 24 months and upto 30 months			5%
Exceeding 30 months			Nil

15. **Refund of premium on death of Insured**

In the event of death of insured in the middle of policy year/during the course of policy period when no claim is paid or in the process to be paid during the policy period, premium shall be refunded on pro-rata basis for balance policy period.
Note - Refund of premium will be calculated from the date of demise subject to
a.Submission of death certificate
b.Intimation for refund should be within 30 days from date of demise of insured.

16. **Claims Procedure**

a. **You or someone claiming on Your behalf must inform Us in writing immediately within 48 hours of hospitalization in case of emergency hospitalization and 48 hours prior to hospitalization in case of planned hospitalization.**
You can intimate Us through E-mail, Fax, Telephone or at our website.

b. You or someone claiming on Your behalf must promptly and in any event within 7 days of discharge from a Hospital give Us the necessary documents along with all original supporting documentation, including but not limited to the following, and other information We ask for, to investigate the claim for Our obligation to make payment for it.

Note: Conditions **a is** precedent to admission of liability under the policy. However, the Company will examine and relax the time limit mentioned in these conditions depending upon the merits of the case.

The Insured Person/s shall submit to the Company: -

a. Duly completed claim form, and
b. Discharge Summary from the hospital
c. Hospital Main bill with breakup details.
d. Aadhar card & PAN card Copies (Not mandatory if the same is linked with the policy while issuance or in previous claim)

The Company shall pay interest as per Insurance Regulatory and Development Authority of India (Protection of Policyholders' Interests) Regulations, 2017, in case of delay in payment of an admitted claim under the Policy.

17. Any medical practitioner authorized by the Company shall be allowed to examine the Insured Person in case of any alleged injury or diseases requiring Hospitalization when and as often as the same may reasonably be required on behalf of the Company.

18. You must take reasonable steps or measures to minimize the quantum of any claim that may be made under this Policy.

19. **Claims Payment**
    a) We shall be under no obligation to make any payment under this Policy unless We have been provided with the documentation and information We have requested to establish the circumstances of the claim or Our liability for it, and unless the Insured Person has complied with his obligations under this Policy.
    b) We will only make payment to You under this Policy. Your receipt shall be considered as a complete discharge of Our liability against any claim under this Policy.
    c) In the event of Your death, We will make payment to the Nominee (as named in the Schedule). No assignment of this Policy or the benefits there under shall be permitted.

20. **Settlement of Claims**
    a) Our Medical Practitioners will scrutinize the claims and flag the claim as settled/ rejected/ pending within the period of 30 days of the receipt of the last necessary documents.
    b) In case of '**pending'** claims, We will ask for submission of incomplete documents.
    c) '**Rejected'** claims will be informed to the Insured Person in writing with reason for rejection.
    d) In the circumstances where a claim warrant an investigation in Our opinion, We 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, We shall settle the claim within 45 days from the date of receipt of last 'necessary' document.
    e) In the cases of delay in the payment of a '**settled'** claim, We shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate which is 2% above the bank rate.
21. All claims under this policy shall be payable in Indian currency.
22. All treatments under this policy shall have to be taken in India.

23. **Fraud**
    i. 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.
    ii. 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 severally liable for such repayment to the insurer.
    iii. For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:
        a. the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;

b. the active concealment of a fact by the insured person having knowledge or belief of the fact;
c. any other act fitted to deceive; and
d. any such actor omission as the law specially declares to be fraudulent

iv. The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

24. **Compliance with policy provisions**

Failure to comply with any of the provisions contained in this Policy shall invalidate all claims hereunder.

25. **Examination of Records**

We may examine Your records relating to the insurance 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. **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.

27. **Legal actions**

Without prejudice to Uniform Provision 26 above, no action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) Days after written evidence has been furnished in accordance with the requirements of this Policy. If no evidence has been furnished within one (1) year of the date upon which it should have been furnished then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable under this Policy.

If We disclaim liability to You for any claim, and if You do not notify Us in writing within one (1) year from the date of receipt of the notice of such disclaimer that You do not accept such disclaimer and intend to recover this claim from Us, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable under this Policy.

28. **Endorsement (Change in Policy)**

i. This Policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped.

ii. The policyholder may be changed only at the time of renewal. The new policyholder must be the legal heir immediate family member Such change would be subject to acceptance by the company and payment of premium (if any). The renewed Policy shall be treated as having been renewed

without break. The policyholder may be changed during the Policy Period only in case of his/her demise him/her moving out of India.

29. **Change of Sum Insured**
The Sum Insured can be changed (increased / decreased) only at the time of Renewal subject to the underwriting norms and acceptability criteria of the Policy.
If You increase the sum insured, the case may be subject to health check-up.
In case of increase in the Sum Insured, the waiting periods will apply afresh in relation to the amount by which the Sum Insured has been enhanced. The quantum of increase shall be at Our discretion and subject to Our underwriting guidelines. Additional premium if any, shall be charged as per terms and conditions of the Policy.

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

31. **Nomination**
The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made For Claim settlement under reimbursement, the Company will pay the policyholder, In the event of death of the policyholder, the Company will pay the nominee (as named in the Policy Schedule/Policy Certificate/Endorsement of any) and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated full and final as of discharge its liability under Policy.

32. **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.

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

34. **Relief under Section 80-D**
Insured Person is eligible for relief under Section 80-D of the IT Act in respect of the amount paid for Health Section by any mode other than cash.

35. **Governing Law**
The construction, interpretation and meaning of the provisions of this Policy shall be determined in accordance with Indian law. The section headings of this Policy are included for descriptive purposes only and do not form part of this Policy for the purpose of its construction or interpretation.

Section II :Shri Criticare Insurance

1. Types of Plans

Policy covers following plans (Insured can choose any one of the following plans):

Standard	Superior	Advanced
1. Cancer of specified severity 2. Myocardial Infarction(First heart attack - of specified severity) 3. Open chest CABG 4. Open heart replacement or repair of heart valves 5. Kidney failure requiring regular dialysis 6. Stroke resulting in permanent symptoms 7. Major organ /bone marrow transplant 8. Permanent paralysis of limbs 9. Multiple sclerosis with persisting symptoms 10. Primary (Idiopathic) Pulmonary Hypertension	1. Cancer of specified severity 2. Myocardial Infarction(First heart attack - of specified severity) 3. Open chest CABG 4. Open heart replacement or repair of heart valves 5. Kidney failure requiring regular dialysis 6. Stroke resulting in permanent symptoms 7. Major organ /bone marrow transplant 8. Permanent paralysis of limbs 9. Multiple sclerosis with persisting symptoms 10. Primary (Idiopathic) Pulmonary Hypertension 11. Coma Of Specified Severity 12. End Stage Liver Failure 13. Loss Of Limbs 14. Major Head Trauma 15. Angioplasty	1. Cancer of specified severity 2. Myocardial Infarction(First heart attack - of specified severity) 3. Open chest CABG 4. Open heart replacement or repair of heart valves 5. Kidney failure requiring regular dialysis 6. Stroke resulting in permanent symptoms 7. Major organ /bone marrow transplant 8. Permanent paralysis of limbs 9. Multiple sclerosis with persisting symptoms 10. Primary (Idiopathic) Pulmonary Hypertension 11. Coma Of Specified Severity 12. End Stage Liver Failure 13. Loss Of Limbs 14. Major Head Trauma 15. Angioplasty 16. Benign Brain Tumor 17. Blindness 18. Deafness 19. End Stage Lung Failure 20. Loss Of Speech 21. Third Degree Burns 22. Motor Neuron Disease With Permanent Symptoms

2. COVERAGE

BENEFITS PROVISIONS while this Policy is in force, the Company shall provide the Benefits of Part I of this Policy stated on the Policy Schedule or any Endorsement when the Insured is diagnosed to be suffering from a Critical Illness set out in Part I of this Policy as defined hereinbelow.

2.1 PART I:

CRITICAL ILLNESS BENEFITS

While this Policy is in force, the Company shall provide the benefit in one lump sum as stated in the Schedule of Benefits subject to the provisions, conditions and limitations contained herein or which may be endorsed

hereinafter if the Insured is diagnosed to be suffering from a Critical Illness as defined hereinabove and if all of the following conditions are satisfied.

a) The Insured Person experiences a Critical Illness specifically listed and defined in this Policy; and
b) The Critical Illness experienced by the Insured is the first incidence of that Critical Illness; and
c) The signs or symptoms of the Critical Illness experienced by the Insured Person commenced more than Ninety (90) days following the Issue Date of the Certificate of Insurance or the last Commencement Date, whichever is later; and
d) None of the General or Specific Limitations or Exclusions specifically contained in this Policy applies.
e) The person has to survive the illness by thirty (30) days or more, from the date of diagnosis.

Only one lump sum payment shall be provided during the Insured's lifetime regardless of the number of Critical Illness, incapacities or treatments suffered by him/her. This Benefit will be terminated after the lump sum payment. If a Critical Illness is diagnosed within Ninety (90) days following the effective date or the date of its last reinstatement of this Policy, whichever is later, the Company's liability shall be limited to the refund of premiums paid under this Policy.

Covered Critical Illnesses:

The Critical Illness Benefit covers any of the following illnesses upon diagnosis being:

Benefits:

1. **Cancer of specified severity**

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

II. The following are excluded –

i. All tumours which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behaviour, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.
ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
iii. Malignant melanoma that has not caused invasion beyond the epidermis;
iv. All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
vi. Chronic lymphocytic leukaemia less than RAI stage 3
vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
viii. All Gastro-Intestinal Stromal Tumours histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
ix. All tumours 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:

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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 Troponins T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. **Open Chest CABG**

I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

II. The following are excluded:
i. Angioplasty and/or any other intra-arterial procedures

4. **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.

5. **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.

6. **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 embolisation from an extra cranial 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:

i. Transient ischemic attacks (TIA)
ii. Traumatic injury of the brain
iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

7. **Major organ /bone marrow transplant**

I. The actual undergoing of a transplant of:

i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
ii. Human bone marrow using haematopoietic stem cells. The undergoing of 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

8. **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.

9. **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.

10. **Primary (Idiopathic) Pulmonary Hypertension**

I. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

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

i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

III. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

11. **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

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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.

12. **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.

13. **Angioplasty**

I. Coronary Angioplasty is defined as percutaneous coronary intervention by way of balloon angioplasty with or without stenting for treatment of the narrowing or blockage of minimum 50 % of one or more major coronary arteries. The intervention must be determined to be medically necessary by a cardiologist and supported by a coronary angiogram (CAG).

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

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

14. **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.

15. **Blindness**

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

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

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

16. **Deafness**

I. Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means "the loss of hearing to the extent that the loss is greater than 90decibels across all frequencies of hearing" in both ears.

17. **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. Dyspnea at rest.

18. **End Stage Liver Failure**

I. Permanent and irreversible failure of liver function that has resulted in all three of the following:
   IV.1. Permanent jaundice; and
   IV.2. Ascites; and
   IV.3. Hepatic encephalopathy.

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

19. **Loss Of Speech**

I. Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, Throat (ENT) specialist.
II. All psychiatric related causes are excluded.

20. **Loss Of Limbs**

I. The physical separation of **two** or more limbs, at or above the wrist or ankle level limbs as a result of injury or disease. This will include medically necessary amputation necessitated by injury or disease. The separation has to be permanent without any chance of surgical correction. Loss of Limbs resulting directly or indirectly from self-inflicted injury, alcohol or drug abuse is excluded.

21. **Major Head Trauma**

I. Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.

II. The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word "permanent" shall mean beyond the scope of recovery with current medical knowledge and technology.

III. The Activities of Daily Living are:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
iv. Mobility: the ability to move indoors from room to room on level surfaces;
v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
vi. Feeding: the ability to feed oneself once food has been prepared and made available.

IV. The following are excluded:

i. Spinal cord injury;
ii.

22. **Third Degree Burns**

I. There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

2.2 PART II

SECOND OPINION BENEFIT: -

The second opinion benefit is valid only if your Critical Illness Insurance Policy is in force and the Insured Person has been diagnosed with any one of the Covered Critical Illnesses defined in this policy.

Covered Benefit: - Transmission of medical records, including images, via computerized software to specialist physicians, in order to obtain an independent second opinion on the diagnosed Critical Illness.

3. AGE

3.1 The minimum insurable age is 18 years except for dependent children for whom the minimum insurable age is 5 yrs.

3.2 The general maximum age of entry is 65 years. The requirement of medical reports will depend on the entry age and maximum renewal age is 70 years.

4. POLICY TENURE

4.1. The maximum policy tenure for individual is upto 3 years.

4.2. Critical Illness operates after a three month waiting period from inception of the policy. Waiting period clause will not be operative for subsequent years.

5. GENERAL EXCLUSIONS

This entire Policy does not provide benefits for any loss resulting in whole or in part from, or expenses incurred, directly or indirectly in respect of:

1. All pre-existing disease/ condition/injuries which are existing when this insurance cover incepts for the first time and the same will be covered after lapse of 48 months.

2. Any Illness, sickness or disease , other than specified as Critical Illness, as mentioned in the policy schedule, or

3. Any Critical Illness resulting from a physical or mental condition which existed before the Policy Issue Date or the last Commencement Date which was not disclosed , or

4. Intentionally self-inflicted Injury or illness, or sexually transmitted conditions, mental or nervous disorder, anxiety, stress or depression, Acquired Immune Deficiency Syndrome (AIDS), Human Immune-deficiency Virus (HIV) infection; suicide, or

5. War, civil war, invasion, insurrection, revolution, act of foreign enemy, hostilities (whether War be declared or not), rebellion, mutiny, use of military power or usurpation of government or military power; or

6. Ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from burning nuclear fuel; or

7. The radioactive, toxic, explosive or other dangerous properties of any explosive nuclear equipment or any part of that equipment; or

8. Participation in winter sports, skydiving/parachuting, hang gliding, bungee jumping, scuba diving, mountain climbing (where ropes or guides are customarily used), riding or driving in races or rallies using a motorized vehicle or bicycle, caving or pot-holing, hunting or equestrian activities, skin diving or other underwater activity, rafting or canoeing involving white water rapids, yachting or boating outside coastal waters (2 miles), participation in any Professional Sport, any bodily contact sport or any other hazardous or potentially dangerous sport for which you are trained or untrained;or

9. Any loss resulting directly or indirectly, contributed or aggravated or prolonged by childbirth or from pregnancy, or

10. Any Critical Illness based on a Diagnosis made by the Insured or his/her Immediate Family Member or anyone who is living in the same household as the Insured or by a herbalists, acupuncturist or other non-traditional health care provider; and

11. Cosmetic or plastic surgery or any elective surgery or cosmetic procedure that improve physical appearance, surgical and non-surgical treatment of obesity (including morbid obesity) and weight control programs, or treatment of an optional nature;

12. Special nursing care, routine health checks or convalescence, Custodial Care, general debility, lethargy, rest cure;

13. Any investigation(s) or treatments not directly related to a Covered Illness or Covered Injury or the conditions or diagnosis necessitating hospital admission;

14. Pre-Existing Diseases - Code- Excl01

    a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with insurer.
    b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
    c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
    d) Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

6. GENERAL CONDITIONS

1. Due Observance

The due observance of and compliance with the terms, provisions, warranties and conditions of this Policy

in so far as they relate to anything to be done or complied with by the Insured and/or the Named Insured shall be a condition precedent to the Company's liability under this Policy.

2. Insured

No person other than a person named as an Insured shall be covered under this Policy unless and until his name has been notified in writing to the Company. Cover under this Policy shall be withdrawn from any person named as an Insured immediately upon the Named Insured delivering written notice of the same to the Company. The Named Insured agrees to and shall hold the Company harmless against any and all claims, costs and expenses that may result because of the incorrect or unintentional cancellation of this insurance in relation to any Insured.

3. Fraud

If the Insured and/ or Named Insured shall make or advance any claim knowing the same to be false or fraudulent as regards amount or otherwise, this Policy shall be void and all claims or payments hereunder shall be forfeited.

4. Free Look Period

You have a period of 15 days from the date of receipt of the first policy document to review the terms and conditions of this Policy. If You have any objections to any of the terms and conditions, You have the option of cancelling the Policy stating the reasons for cancellation. If you have not made any claim during the Free look period, you shall be entitled to refund of premium subject to,

a. a deduction of the expenses incurred by Us on Your medical examination, stamp duty charges, if the risk has not commenced,
b. a deduction of the stamp duty charges, medical examination charges & proportionate risk premium for period on cover, If the risk has commenced
c. a deduction of such proportionate risk premium commensurating with the risk covered during such period, where only a part of risk has commenced

Free Look Period will not be applicable for renewal Policies.

5. Renewal conditions:

1. Renewal of policy would be offered to the insured unless on grounds of moral hazard, misrepresentation, and fraud by the insured and would be subject to no claim being made on the policy during the previous year and payment of the renewal premium made prior to expiry of the policy and not later than 30 days post the expiry of the policy.
2. If a claim was paid during this policy period for any one of the covered critical illness, then this policy will not be renewed subsequently for any other critical illness.
3. If the policy is renewed for enhanced sum insured, then coverage for additional sum insured shall be as if a new policy has been issued for the additional sum insured. In other words, all policy conditions shall apply to the enhanced sum insured as if the same is covered under a fresh policy.
4. If the insured was covered under a benefit policy from any other insurer in India covering the same health condition /s and under the same terms as are being covered under this policy for the previous 12 continuous months, then the 90 days waiting period clause shall not apply for such renewals, provided the renewal is continuous.
5. In cases where Insured approaches for renewal after lapse of 30 days of policy expiry, the proposal will be treated as fresh proposal and it will be underwritten as if the proposal is received for the first time.
6. The company may from time to time revise the premium rates/terms and conditions based on Company's experience and to factor increasing costs, subject to prior approval from the regulator.

6. Cancellation

We may at any time cancel the Policy on grounds of misrepresentation, fraud, non-disclosure of material fact by sending notice in writing by Registered A/D to Insured Person at Insured Perosn's last known address at least 15 days in advance in which case We shall refund pro-rata premium for the unexpired

portion of the policy on the date of cancellation, provided no claim has occurred upto the date of cancellation.

The Insured may also give 15 days' notice in writing, to the Company, for the cancellation of this policy,

in which case the Company shall refund the premium as specified below:-

Period on risk	% of Annual Premium refunded		
	1 Year Policy	2 Year Policy	3 Year Policy
Upto 1 month	70%	75%	80%
Exceeding 1 month and upto 3 months	55%	70%	70%
Exceeding 3 months and upto 6 months	30%	55%	65%
Exceeding 6 months and upto 12 months	NIL	30%	45%
Exceeding 12 months and upto 18 months		10%	30%
Exceeding 18 months and upto 24 months		NIL	10%
Exceeding 24 months and upto 30 months			5%
Exceeding 30 months			NIL

7. Territory:

This Policy applies to incidents anywhere in the world unless limited by Us through endorsement.

8. Concealment or fraud:

The entire Policy/ Certificate of Insurance will be void if, whether before or after a loss, You have, related to this insurance:

1. intentionally or recklessly or otherwise concealed, not disclosed or misrepresented what we consider to be any material fact or circumstance;
2. engaged in what we consider to be fraudulent, dishonest or deceitful conduct; or
3. made false statements.

9. Notice of claim/loss:

It is a condition precedent to Our liability hereunder that written notice of claim must be given by You to Us within 7 days after an actual or potential loss begins or as soon as reasonably possible and in any event not later than 30 Days after an actual or potential loss begins.

10. Claim forms:

We, upon receipt of a notice of claim, will furnish Your representative with such forms as We may require for filing proofs of loss.

11. Time for filing claim forms and evidence:

Completed claim forms and written evidence of loss must be furnished to Us within thirty (30) Days after the date of such loss. Failure to furnish such evidence within the time required shall not invalidate nor reduce any claim if You can satisfy us that it was not reasonably possible for You to give proof within such time. However, no proof will be accepted if furnished later than one (1) year from the time the loss occurred.

12. Time of payment of claim:

Benefits payable under this Policy will be paid within a reasonable time upon receipt of due written evidence of such loss and any other documentation, information and assistance that We may request You pursuant to Uniform Provision 10 above.

13. Payment of claim:

All claims under this Policy that are payable to You / Your assignee shall be paid in Indian currency.

14. Arbitration:

If any dispute or difference shall arise as to the quantum of claim to be paid under this 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 to 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 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 Indian 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 denied, 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 the award by such Arbitrator/Arbitrators of the amount of the loss or damage shall be first obtained.

It is also hereby further expressly agreed and declared that if the Company shall disclaim liability to the Insured for anyclaim hereunder and such claim shall not, within 12 calendar months from the date of such disclaimer have been madethe subject matter of a suit in a court of law, then the claim shall for all purposes be deemed to have been abandoned andshall not thereafter be recoverable hereunder.

In the event that these arbitration provisions shall be held to be invalid then all such disputes or differences shall bereferred to the exclusive jurisdiction of the Indian Courts.

15. Assignment of indemnities:

Indemnity, if any, in case of Your loss of life is payable as defined in the Policy Schedule by default to the assignee declared by You; indemnity is payable to Your estate. Any payment We make in good faith pursuant to this provision shall fully discharge Us to the extent of the payment.

16. Consent of assignee:

Consent of the assignee, if any, shall not be a pre-requisite for any change of assignee or to any other changes in this Policy.

17. Change of assignee:

No change of assignee under this Policy shall bind Us, unless consent / such change thereto is formally endorsed thereon by Our authorized officer.

18. Medical examination:

We, at Our own expense, shall have the right and opportunity to obtain a post mortem examination report of Your body as permitted by law. You or Your estate's compliance with the need for such examination report is a condition precedent to establishing liability under the Policy.

19. Portability

Portability means transfer by an individual health insurance policyholder (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.

If the Policyholder/ Insured Person renew with the Company, without break, any similar individual health insurance policy from any insurance company registered with IRDA, then the Waiting Periods as defined in exclusions shall be reduced by the number of years of continuous coverage under such health insurance policy with the previous insurer(s).

The Company's total liability for payment of all claims in aggregate, incurred during the Policy Period, on account of Portability shall not exceed Sum Insured Limit for Portability as defined in Policy Schedule.

The Waiting Periods as defined in policy exclusions shall be applicable individually for each Insured

Person and Claims shall be assessed accordingly

20. Legal actions:

Without prejudice to Uniform Provision 15 above, no action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) Days after written evidence has been furnished in accordance with the requirements of this Policy. If no evidence has been furnished within one (1) year of the date upon which it should have been furnished then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable under this Policy.

If We disclaim liability to You for any claim, and if You do not notify Us in writing within one (1) year from the date of receipt of the notice of such disclaimer that You do not accept such disclaimer and intend to recover this claim from Us, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable under this Policy.

21. Misstatement of Age:

If Your Age has been misstated, all amounts payable under this Policy shall be adjusted to the coverage amount that would have been purchased for the premium paid. In the event Your Age has been misstated, and if according to Your correct Age, the coverage provided by the Policy would not have become effective, or would have ceased prior to the acceptance of such premium or premiums, then Our liability during the period You are not eligible for coverage, shall be limited to the refund, upon written request, of all premiums paid for the period not covered by the Policy.

22. Compliance with policy provisions:

Failure to comply with any of the provisions contained in this Policy shall invalidate all claims hereunder.

23. Limitations:

Multiple policies: If an Insured Person suffers a covered Illness or Sickness or Disease for which benefits, are payable under more than one Critical Illness Policy issued by Us, the maximum amount payable under all Policies combined will not exceed the amount payable under the Policy which pays the largest benefit.

24. Payment of Interest

In case of delay of seven days or more in payment of claim after the acceptance by the insured, the Company will pay interest on the claim amount at a rate which is 2% above the bank rate for the period of delay

25. Other interest:

No person(s) other than you and/or your nominee (s) named by you in this application form can claim or sue us under this policy.

26. Change of occupation:

If You sustain a loss after having changed occupation to one We classify as more hazardous than the stated in the Proposal or while doing for compensation anything pertaining to an occupation so classified, We will pay such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits We have fixed for such more hazardous occupation.

27. Associated companies and change in risk:

If this policy covers associated companies, You must provide a list of these companies. If Your Associated companies or Your business activities change from those You have told Us about and summarized in the Proposal and Business description in the Schedule, You must tell Us immediately. We must confirm in writing that We accept the changes.

Section III :Shri Vector Care Insurance

1. SCOPE OF COVERAGE

If the Insured or the Insured Person(s), as the case may be, is diagnosed as suffering from any of covered Vector Borne disease during the Policy Period and Hospital admission longer than 24 continuous hours, the Company shall pay a lump sum payment of 100%, as specified under the Policy Schedule, subject to Sum assured limits, terms, conditions, definitions and exclusions contained or otherwise expressed in the Policy Schedule.

Following are the vector borne disease covered under the policy

A. Malaria

A registered medical practitioner should confirm diagnosis of Malaria with confirmatory tests indicating presence of Plasmodium falciparum/ vivax/ malariae in the patient's blood by laboratory examination countersigned by a pathologist/microbiologist in peripheral blood smear or positive rapid diagnostic test (antigen detection test).
Continuous Hospitalization of 24 hrs should be necessary along with high fever and shaking chills.
Please note Indoor case papers should be mandatorily obtained for each claim and the diagnosis of admission should be malaria and its complications, if any.
Below are the specific exclusions for this condition:

- Any Treatment other than for malaria and its complications
- Hospitalization less than 24 hours

B. Dengue

The applicant will be eligible for the benefit pay out in case of being diagnosed with Dengue confirmed by a registered medical practitioner (RMP). Hospitalization must be necessary as advised by the RMP and the Laboratory examination result countersigned by a pathologist/microbiologist must confirm the following:

- Decreasing platelet levels- less than 100,000 cells/mm3; and
- Immunoglobulins/PCR test showing positive results for Dengue

Please note Indoor case papers should be mandatorily obtained for each claim and the diagnosis of admission should be Dengue in addition to the above two conditions.
Below are the specific exclusions for this condition:

- Any Treatment other than for Dengue (as defined above)
- Hospitalization less than 24 hours

C. Lymphatic Filariasis (Payout only once in lifetime)

Commonly known as elephantiasis, a registered medical practitioner must confirm the same and Laboratory examination result must be documented with presence of microfilariae in a blood smear by microscopic examination and along with any two of the following criteria:

Clear and visible manifestation of the disease as follows:

- lymphoedema,
- elephantiasis and
- scrotal swelling

Please note Indoor case papers should be mandatorily obtained for each claim and the diagnosis of admission should be Filariasis in addition two of the above conditions. Claim against 'Lymphatic Filariasis shall be paid only once in the entire lifetime of the Insured upon first occurrence post start of coverage under this policy.

Below are the specific exclusions for this condition:

- Any Treatment other than for Filariasis and its complications (as defined above)
- Hospitalization less than 24 hours

D. Kala-azar

Visceral leishmaniosis, also known as kala-azar, is characterized by irregular bouts of fever,substantial weight loss, swelling of the spleen and liver, and anaemia.

The diagnosis must be confirmed by a registered medical practitioner and by parasite demonstration in bone marrow/spleen/lymph node aspiration or in culture medium, as the confirmatory diagnosis or positive serological tests for kala azar should clearly indicate the presence of this disease.

Please note Indoor case papers should be mandatorily obtained for each claim and the diagnosis of admission should be Kala Azar.

Below are the specific exclusions for this condition:

- Any Treatment other than for Kala Azar (as stated above)
- Hospitalization less than 24 hours

E. Japanese Encephalitis

Characterized by rapid onset of high fever, headache, neck stiffness, disorientation, coma, seizures,and spastic paralysis. To confirm Japanese Encephalitis (JE) infection and to rule out other causes of encephalitis requires a laboratory testing of serum or preferably cerebrospinal fluid.
The diagnosis must be confirmed by a registered medical practitioner and positive serological test for JE by immunoglobulin M (IgM) antibody capture ELISA (MAC ELISA) for serum and cerebrospinal fluid (CSF)
Please note Indoor case papers should be mandatorily obtained for each claim and the diagnosis of admission should be Japanese Encephalitis.
Below are the specific exclusions for this condition:

- Any treatment other than for Japanese Encephalitis (as stated above)
- Hospitalization less than 24 hours

F. Chikungunya

Chikungunya is characterized by an abrupt onset of fever with Joint pain. Other common signs and symptoms include muscle pain, headache, nausea, fatigue and rash.
The diagnosis must be documented by a registered medical practitioner and by Serological tests,such as enzyme-linked immunosorbent assays (ELISA), confirming the presence of IgM and IgG anti-chikungunya antibodies.
Please note Indoor case papers should be mandatorily obtained for each claim and the diagnosis of admission should be Chikungunya.
Below are the specific exclusions for this condition:

- Any Treatment other than for Chikungunya
- Hospitalization less than 24 hours

G. Zika Virus

People with Zika virus disease can have symptoms like mild fever, skin rash, conjunctivitis, muscle and joint pain, malaise or headache.
A diagnosis of Zika virus infection should be confirmed by a registered medical practitioner and by plaque-reduction neutralization testing (PRNT). PRNT is performed by CDC or a CDC-designated confirmatory testing laboratory to confirm presumed positive, equivocal, or inconclusive IgM results.

Please note Indoor case papers should be mandatorily obtained for each claim and the diagnosis of admission should be Zika virus.

Below are the specific exclusions for this condition:

- Any treatment other than for Zika virus (as stated above)
- Hospitalization less than 24 hours

Shriram General Insurance Co. Ltd.
IN PARTNERSHIP WITH THE **Sanlam** GROUP
Regd.& Corpt. Office: E-8, EPIP, RIICO Industrial Area, Sitapura, Jaipur (Rajasthan) – 302022
Phone: +91-141-3928400, 3951111, Fax: +91-141-2770692, 2770693
Website: www.shriramgi.com, E-mail: customer.feedback@shriramgi.in
Toll Free: 1800-103-3009, 1800-300-30000, ISO/IEC 27001:2013 certified

2. COVERAGE OPTION

OPTION 1- COVERAGE WITHOUT RESTORATION

1. **Individual Cover**
   Upon admission of any claim against one of the listed diseases, 100% sum assured will be paid and policy terminates subject to other terms and condition of policy.

2. **Family Floater Cover**

   Upon admission of a claim to any member against one of the listed diseases, 100% sum assured will be paid and policy terminates for the member for whom claim is admitted while policy continues for the remaining members, if more than one claim is allowed under the floater policy. If only one claim is allowed, policy will terminate after admission of the first claim. (refer table below for the number of members and allowed number of claims).

Illustration

i. Family floater policy covering two members.

Policy is bought on 01 January 2019 covering two members without restoration and if any of the member is diagnosed with Dengue on 01 February 2019. We will pay 100% sum assured (subject to fulfillment of other terms and conditions) and the policy shall terminate for both members as maximum number of claim allowable is one.

If the Policy is renewed within 60 days from the date of admission of the previously paid claim, a 60 days cooling off period shall apply for Dengue in the new policy for member for whom claim is admitted. However other members will be continuously covered (post renewal) without any cooling off period.

ii. Family Floater Policy covering more than 2 members

Policy is bought on 01 January 2019 covering more than two members without restoration and if any of the member is diagnosed with Dengue on 01 February 2019. We will pay 100% sum assured (subject to fulfillment of other terms and conditions) and the policy coverage shall cease for named insured member for whom the claim is admitted.
The policy shall continue for rest of the members covered under the policy. However after payment of 100% sum assured against the second claim (subject to fulfillment of other terms and conditions), the policy shall terminate for all covered members as maximum number of allowable claim are two.

Scenario. No.	Covered Members	Max covered members per policy	Max number of claims per policy
1	Self	1	1
2	Self+ Spouse	2	1
3.	Self + Spouse+ 1or 2 Member (Child or Parent)	3 or 4	2
4	Self+ Spouse+3or 4 members (Child or/and parents)	5 or 6	2

Under option 3 and 4 above, irrespective of the number of parents / parents in laws covered, max number of members covered in family will not exceed the numbers mentioned above.

OPTION 2- COVERAGE WITH RESTORATION

1. **Individual Basis**.

Upon admission of any claim against one of the listed diseases, sum assured will be restored to 100% and the policy continues until allowable number of claims is made under the policy or end of the policy term whichever is earlier subject to cooling off period.

Illustration –

If policy is bought on 01 January 2019 by an individual with restoration and Dengue is diagnosed on 1 February 2019. We will pay 100% sum assured (subject to fulfillment of other terms and conditions) and sum assured will be restored to 100%. Coverage will continue for all diseases except Dengue during the 60 days cooling off period.
However coverage for Dengue will be restored with effect from 03 April 2019 (60 days post 1 February 2019)

2. **Family floater**

Upon admission of any claim against one of the listed diseases, sum assured will be restored to 100% and policy continues until allowable number of claims is made under the policy or end of the policy term whichever is earlier subject to cooling off period.

Illustration

If Policy is bought on 01 January 2019, family floater with restoration and two members are covered. If any of the members is diagnosed with Dengue on 01 February 2019 .We will pay 100% sum assured (subject to fulfillment of other terms and conditions) to named insured member for whom the claim has been made and sum assured will be restored to 100%. Coverage will continue for all diseases except Dengue during the 60 days cooling off period for member for whom claim has been paid. Coverage for this member against Dengue will be restored with effect from 03 April 2019 (60 days post 1 February 2019).

Other members will continue to be covered for all diseases without any cooling off period. Since two claims are allowed, after the second claim on any of the member, policy will terminate.

Scenario. No.	Covered Members	Max covered members per policy	Max number of claims per policy*
1	Self	1	2 claims including 1 restoration
2	Self+ Spouse	2	2 claims including 1 restoration
3.	Self + Spouse+ 1or 2 Member (Child or Parent/ Parent In law)	3 or 4	6 claims including 3 restorations
4	Self+ Spouse+ 3 or 4 members (Child or/and Parents/Parent in law)	5 or 6	6 claims including 3 restorations

***Per member max of 2 claims per policy year is allowed.**
Under option 3 and 4 above, irrespective of the number of parents / parents in laws covered, max number of members covered in family will not exceed the numbers mentioned above.

3. POLICY TERMINATION

The policy will terminate on death of the life assured or on payment of all allowable claims under the policy or end of the policy term, whichever is earlier.

4. EXCLUSION

This entire Policy does not provide benefits for any loss resulting in whole or in part from, or expenses incurred, directly or indirectly in respect of:

I. General Exclusion

1. Any condition other than Malaria, Lymphatic Filariasis, Dengue Fever, Japanese Encephalitis, and Kala Azar, Chikungunya or Zika virus as defined under this policy.
2. Admission to hospital for less than 24 hours.
3. Any of the covered vector borne disease diagnosed with in the waiting period
4. Diagnosis and treatment outside India. However, this exclusion shall not be applicable in the following countries: Canada, Dubai, Hong Kong, Japan, Malaysia, New Zealand, Singapore, Switzerland, USA, and countries of the European Union. The insurer may review the above list of accepted foreign countries from time to time. Claims documents from outside India are only acceptable in English language unless specifically agreed otherwise, and duly authenticated.
5. Any claim during waiting period

II. Specific Exclusion

1. Any of the listed vector borne disease diagnosed within the first 15 days of the date of commencement of the Policy is excluded. This exclusion shall not apply to an Insured/Insured Persons, as the case may be, for whom coverage has been renewed without a break, for subsequent years provided there are NIL claims in the previous Policies.

2. The initial waiting period of 15 days will be increased to 60 days, if the insured is suffering or has suffered within 60 days prior to the date of proposal, from any one of the listed vector borne disease except Lymphatic Filariasis at the time of taking the policy.

3. In case, if the insured is suffering or has suffered within 60 days prior to the date of proposal, from Lymphatic Filariasis at the time of taking the policy, Lymphatic Filariasis will be excluded from the policy and the other listed vector borne disease shall have an initial waiting period increased to 60 days

5. CONDITION(S)

1. Due Observance

The due observance of and compliance with the terms, provisions, warranties and conditions of this Policy in so far as they relate to anything to be done or complied with by the Insured and/or the Named Insured shall be a condition precedent to the Company's liability under this Policy

2. Insured

No person other than a person named as an Insured shall be covered under this Policy unless and until his name has been notified in writing to the Company. Cover under this Policy shall be withdrawn from any person named as an Insured immediately upon the Named Insured delivering written notice of the same to the Company. The Named Insured agrees to and shall hold the Company harmless against any and all claims, costs and expenses that may result because of the incorrect or unintentional cancellation of this insurance in relation to any Insured.

3. Communications

- Any communications, notifications or declarations meant for Us must be in writing and delivered to Our address specified in the Schedule.
- Any communication meant for You will be sent by Us to Your address shown in the Schedule. You must notify Us immediately of any change in Your address.
- Our agents are not authorized to receive communications, notices or declarations on Our behalf.

Shriram General Insurance Co. Ltd.
IN PARTNERSHIP WITH THE **Sanlam** GROUP
Regd.& Corpt. Office: E-8, EPIP, RIICO Industrial Area, Sitapura, Jaipur (Rajasthan) – 302022
Phone: +91-141-3928400, 3951111, Fax: +91-141-2770692, 2770693
Website: www.shriramgi.com, E-mail: customer.feedback@shriramgi.in
Toll Free: 1800-103-3009, 1800-300-30000, ISO/IEC 27001:2013 certified

4. Fraud

If the Insured and/ or Named Insured shall make or advance any claim knowing the same to be false or fraudulent as regards amount or otherwise, this Policy shall be void and all claims or payments hereunder shall be forfeited.

5. Free Look Period

You have a period of 15 days from the date of receipt of the first policy document to review the terms and conditions of this Policy. If You have any objections to any of the terms and conditions, You have the option of cancelling the Policy stating the reasons for cancellation. If you have not made any claim during the Free look period, you shall be entitled to refund of premium subject to,

A deduction of the expenses incurred by Us on Your medical examination, stamp duty charges, if the risk has not commenced,
A deduction of the stamp duty charges, medical examination charges & proportionate risk premium for period on cover, If the risk has commenced
A deduction of such proportionate risk premium commensurating with the risk covered during such period ,where only a part of risk has commenced
Free Look Period will not be applicable for renewal Policies.

6. Cooling off period means no claim period of 60 days will be applicable from the date of admission of a claim against a covered condition in case of restoration or immediate renewal of the policy.

Coverage without restoration

No cooling off period will be applicable since each covered individual is covered for 100% sum assured and once the claim is admitted, the coverage terminates.
Under family floater, other members will be continuously covered without any cooling off period.

Cover with restoration

Under the restored cover, insured will be covered against all conditions* except the condition for which the claim was made in the previous policy. This claimed condition will be covered after 60 days cooling off period post restoration. Further, the cooling off period will continue to the next policy year in policy renewal falls within this period.

Under family floater, other members will be continuously covered without any cooling off period.

*If a claim is admitted against Lymphatic Filariasis upon renewal of policy, coverage will be available for all conditions except Lymphatic Filariasis. For Lymphatic Filariasis, once the sum assured is paid for any life, no other claim for this particular condition shall be paid to the policyholder in the entire lifetime of the policyholder; the premiums will be adjusted accordingly in the next renewal.

7. Renewal

A. Renewal with Nil Claims

i. Under normal circumstances, lifetime renewal benefit is available under the Policy except on the grounds of fraud, misrepresentation or moral hazard or non-co-operation by the Insured/Insured Persons or if any false statement, or declaration is made or used or Upon the occurrence of an event of Vector Borne disease.

ii. In case of our own Company's renewal a grace period of 30 days is permissible and the Policy will be considered as continuous for the purpose of waiting period. Any claim incurred as a result of Insured disease contracted during the grace period will not be admissible under the Policy.

iii. For renewals received after completion of 30 days grace period, afresh application of this policy should be submitted to Us, it would be processed as per a new business proposal.

iv. Premium payable or any changes in terms & conditions on renewal and on subsequent continuation of cover are subject to change with prior approval from IRDA

B. Renewal upon admission of a claim**:**

i. Upon payment of claim the Insured has option to renew the Policy with immediate effect or on a later date as per below terms & conditions
   - If the Policy is renewed within 60 days from the date of admission of the previously paid claim for the named insured a 60 days cooling off period shall apply for the same disease in the new Policy opted, however there would be no waiting period for other listed vector borne diseases.
   - If the Policy is renewed post 60 days from the date of admission of the previously paid claim for the named insured then a fresh waiting period of 15 days shall apply for all listed vector borne diseases

ii. For Lymphatic Filariasis, once the sum assured is paid for any life,no other claim for this particular condition shall be paid to the Named insured in the entire lifetime.

8. Cancellation

We may at any time cancel the Policy on grounds of misrepresentation, fraud, non-disclosure of material fact by sending notice in writing by Registered A/D to the insured at his/her last known address at least 15 days in advance in that case we shall refund pro-rata premium for the unexpired portion of the policy on the date of cancellation, provided no claim has occurred till the date of cancellation.

The Insured may also give 15 days' notice in writing, to the Company, for the cancellation of this policy, in which case the Company shall retain the premium for the period this Policy has been in force at the Company's short period scales.

Period on risk	**% of Annual Premium refunded**		
	1 Year Policy	2 Year Policy	3 Year Policy
Upto 1 month	70%	75%	80%
Exceeding 1 month and upto 3 months	55%	70%	70%
Exceeding 3 months and upto 6 months	30%	55%	65%
Exceeding 6 months and upto 12 months	Nil	30%	45%
Exceeding 12 months and upto 18 months		10%	30%
Exceeding 18 months and upto 24 months		Nil	10%
Exceeding 24 months and upto 30 months			5%
Exceeding 30 months			Nil

9. When Claim Arise

A. Claims Procedure

a) We must be informed of any event or occurrence that may give rise to a claim under this Policy within 48 hours of hospitalization of the illness. You can intimate us through letter, email, fax or telephone.

b) You or someone claiming on Your behalf must promptly and in any event within 15 days of discharge from a Hospital give Us the necessary documents along with all original supporting

documentation, including but not limited to the following, and other information We ask for, to investigate the claim for Our obligation to make payment for it

i. Our claim form duly completed (along with captioned documents) and signed by/ on behalf of the Insured Person.
ii. Original Discharge Summary or copy duly attested by hospital

iii. A precise diagnosis of the treatment for which a claim is made.
iv. Treating doctor's certificate regarding the duration of the illness & etiology.
v. KYC documents.
vi. Laboratory reports.

B.Claims Payment

a) We shall be under no obligation to make any payment under this Policy unless We have been provided with the documentation and information We have requested to establish the circumstances of the claim or Our liability for it, and unless the Insured Person has complied with his obligations under this Policy.
b) We will only make payment to You under this Policy. Your receipt shall be considered as a complete discharge of Our liability against any claim under this Policy.
c) In the event of Your death, We will make payment to the Nominee (as named in the Schedule). No assignment of this Policy or the benefits there under shall be permitted.

C.Settlement of Claims

a) Our Medical Practitioners will scrutinize the claims and flag the claim as settled/ rejected/ pending within the period of 30 days of the receipt of the last necessary documents.
b) In case of '**pending'** claims, We will ask for submission of incomplete documents.
c) '**Rejected'** claims will be informed to the Insured Person in writing with reason for rejection.
d) In the circumstances where a claim warrant an investigation in Our opinion, We 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, We shall settle the claim within 45 days from the date of receipt of last 'necessary' document.
e) In the cases of delay in the payment of a '**settled'** claim, We shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate which is 2% above the bank rate.
f) In case multiple Shri Vector Care Insurance policies are opted by single insured person, Our maximum liability for claim towards a single hospitalization shall be restricted to Sum assured of ₹75,000/- (all policies put together).

10. Portability

Portability means transfer by an individual health insurance policyholder (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.

If the Policyholder/ Insured Person renew with the Company, without break, any similar individual health insurance policy from any insurance company registered with IRDA, then the Waiting Periods as defined in exclusions shall be reduced by the number of years of continuous coverage under such health insurance policy with the previous insurer(s).

The Company's total liability for payment of all claims in aggregate, incurred during the Policy Period, on account of Portability shall not exceed Sum assured Limit for Portability as defined in Policy Schedule.

The Waiting Periods as defined in policy exclusions shall be applicable individually for each Insured Person and Claims shall be assessed accordingly.

11. Legal actions:

Without prejudice to Uniform Provision 8.15, no action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) Days after written evidence has been furnished in accordance with the requirements of this Policy. If no evidence has been furnished within one (1) year of the date upon which it should have been furnished then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable under this Policy.

If We disclaim liability to You for any claim, and if You do not notify Us in writing within one (1) year from the date of receipt of the notice of such disclaimer that You do not accept such disclaimer and intend to recover this claim from Us, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable under this Policy.

12.Compliance with policy provisions:

Failure to comply with any of the provisions contained in this Policy shall invalidate all claims hereunder.

13. Territorial Limits and Law

- We cover sickness sustained by the Insured Person during the Policy Period anywhere in India.
- All medical/ surgical treatments including investigations under this policy shall have to be taken in India, however if diagnosis and treatment is taken in following countries/ cities: Canada, Dubai, Hong Kong, Japan, Malaysia, New Zealand, Singapore, Switzerland, USA, and countries of the European Union, the same would be accepted, provided that the claims documents are only in English language unless specifically agreed otherwise, and duly authenticated. The admissible claims thereof shall be payable in Indian currency (Indian Rupees).
- The construction, interpretation and meaning of the provisions of this Policy shall be determined in accordance with Indian Law.
- The Policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by Us, which approval shall be evidenced by an endorsement on the Schedule.

14. Examination of Records

We may examine Your records relating to the insurance 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

15. 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.

Shriram General Insurance Co. Ltd.

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16. Endorsement (Change in Policy)

i. This Policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped.

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

17. Change of Sum assured

Sum assured can be changed (increased/ decreased) only at the time of renewal, subject to underwriting by the Company.

18. Terms and condition of the Policy

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

19. Nomination:

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made For Claim settlement under reimbursement, the Company will pay the policyholder, In the event of death of the policyholder, the Company will pay the nominee (as named in the Policy Schedule/Policy Certificate/Endorsement of any) and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated full and final as of discharge its liability under Policy.

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Section IV :Shri Individual Personal Accident Insurance

The Company hereby agrees subject to the terms and conditions contained herein or endorsed or otherwise expressed hereon to pay the Insured / Insured Person, his/her nominee or the legal representatives, as the case may be, in respect of insured events occurring during the period of insurance stated in the Schedule, in the manner and to the extent set forth in this Policy.

1. COVERAGE

Our liability to make payment to insured person named in the schedule for one or more of the events described from I to IV below, is limited to the Sum Insured mentioned in each of the respective section (I to IV)

Insured Person agree that We shall deduct from any amount We have to pay under I to IV any amount that We have already paid under any of I to IV, so that our total payments do not exceed the Capital Sum Insured under this policy. However, if We become liable to make payment under I or IV, then this insurance will cease as far as insured person named in the schedule are concerned. If insured has opted VII, then this section will continue till the expiry of policy.

I. Accidental Death

We will pay the nominee 100% of the sum insured shown under each of the Basic Plan, Basic Plus Plan, Advance Plan or Comprehensive Plan that is selected by Insured Person, if during the Policy Period, insured person named in the schedule meet with any Accidental Bodily Injury, that causes his/her death within 12 Months from the date of such accident and such accident is the sole and direct cause of such death.

II. Permanent Total Disability

We will pay Insured Person100% of the sum insured shown under Basic Plus Plan, Advance Plan or Comprehensive Plan that is selected by Insured Person, if insured person named in the schedule meet with Accidental Bodily Injury during the Policy Period that causes Permanent Total Disability (shown in the table below) within 12 months from the date of such accident and such accident is the sole and direct cause of such Permanent Total Disability.

Table 1

Disability	% of SI
Loss of sight of both the eyes	100%
Loss of two entire hands or two entire feet	100%
Loss of one entire hand and one entire foot	100%
Loss of sight of one eye and loss of one entire foot or hand	100%
Complete loss of hearing of both ears and complete loss of Speech	100%
Complete loss of hearing of both ears and loss of one limb	100%
Complete loss of hearing of both ears and loss of sight of one eye	100%
complete loss ofspeechand loss of one limb	100%
complete loss of speech and loss of sight of one eye	100%

III. Permanent Partial Disability

If insured person named in the schedule meet with Accidental Bodily Injury during the Policy Period that causes Permanent Partial Disability within 12 months from the date of such accident and such accident is the sole and direct cause of such Permanent Partial Disability, then We will pay the percentage (shown in the table below)of the sums insured shown under each of the Schedule headings Advance Plan and Comprehensive Plan that is selected by the insured, however in case of multiple permanent partial disability maximum payable amount will not be more than 100% of Capital Sum Insured.

Table 2

Nature of Disability	Percentage of Sum Insured Payable
An arm at the shoulder joint	70%
An arm above the elbow joint	65 %
An arm beneath the elbow joint	60 %
A hand at the wrist	55 %
A thumb	20 %
An index finger	10 %
Any other finger	5 %
A leg above mid-thigh	70 %
A leg up to mid-thigh	60 %
A leg up to beneath the knee	50 %
A leg up to mid-calf	45 %
A foot at the ankle	40 %
A large toe	5 %
Any other toe	2 %
An eye	50%
Hearing of one ear	30 %

However, if the insured named in the schedule were already suffering from Permanent Partial Disability before the date he/she met with Accidental Bodily Injury, then the amount We pay will be reduced by that extent as decided by our medical advisors according to the degree of Permanent Partial Disability from which the insured named in the schedule were already suffering.

IV. Temporary Total Disability

If the insured named in the schedule suffers Accidental Bodily Injury during the Policy Period shown under each of the Schedule headings **Comprehensive Plan** that is selected by the insured. Which is the sole and direct cause of a temporary disability which completely prevents the insured person(s) from engaging in his/her respective occupation, then We will make a weekly payment of **1 % of capital sum insured per week, maximum up to Rs 50000/- per week, subject to:**

IV.1. The insured(s)'temporary disablement is certified by a Medical Practitioner/ Physician.

IV.2. We will make the first payment when the insured person(s) named in the schedule satisfy us that the Accidental Bodily Injury has completely prevented the insured person (s) from engaging in his/her occupation.

IV.3. We will stop making payments when We are satisfied that the insured person(s) named in the schedule can engage in his/her occupation again, or when We have made **payments for a maximum period of 100 weeks from the date the insured person(s) met with the Accidental Bodily Injury, whichever is earlier.**

IV.4. His/ Her actual earnings per week.

V. Additional Benefit

V.1. Transportation of Mortal Remains

If We have accepted a claim under 3.1 - Accidental Death, for death of the insured named in the schedule, and then We will pay towards the actual cost of transporting the remains of the deceased from the place of death to a hospital, cremation ground or burial ground. The amount We pay will be limited to the lower of Rs.5, 000/- or 2% of the sums insured shown as under with respect to any one of the plan (Basic Plan, Basic Plus Plan, Advance Plan or Comprehensive Plan) that is selected by the insured.

V.2. Children's Education Benefit

If We have accepted a claim under either I - Accidental Death or II - Permanent Total Disability, then We will make a onetime payment of 2% of the benefit under I or II for each child towards the cost of education, up to first 2 of the insured's dependent children who are studying. In case of more than two children then company will pay to first two children only.

VI. Hospital Confinement Allowance

(Available only if the schedule shows insured person opted for it)

If We have accepted a claim under I to IV, then We will pay Rs.1000/- for each complete calendar day, that insured person had to be hospitalized (within or after the policy period) for medical reasons, because of such Accidental Bodily injury. However, the amount we pay under this cover for each policy period, will be limited to Rs.30, 000/- even if there is more than one claim

VII. Accidental Hospitalisation Cover

(Available only if the schedule shows insured person opted for it)

If during the period of Insurance, insured person, sustains bodily injury resulting from accident during the policy period and is hospitalized, because of such accident, on the advice of a Medical Practitioner as an in-patient for twenty four (24) continuous hours or more, then We will reimburse Insured Person the necessary Usual, Reasonable and Customary In-House Medical Expenses actually incurred by Insured Person, within twelve (12) months from the date of Accidental Injury, up to the Actual Hospitalization Expenses or Sum Insured stated in the schedule under this heading whichever is lower, subject to terms and conditions of this policy Cover for room rent is subject to maximum of 1% of Sum Insured stated in the schedule under this heading if such sum insured is less than equal to Rs 2 lakhs.

The medical expenses reimbursable would include:

i. The reasonable charges that insured person named in the schedule necessarily incur on the advice of a Medical Practitioner As an in-patient in a Hospital for accommodation; emergency room, Intensive Care Unit, nursing care; the attention of medically qualified staff; fees of physicians, charges for laboratory test, prescription medicines or drugs, therapeutics, anaesthetics (including administration of anaesthetics), transfusions, artificial Limbs or eyes (excluding repair or replacement of these items), x-rays, prosthetic appliances, undergoing Medically Necessary procedures and medical consumables.

ii. Ambulance charges for carrying insured person from the site of accident to the nearest hospital subject to a limit of Rs2500 per claim.

The medical expenses reimbursable would not include:

i. Any Usual and reasonable In-Hospitalization Medical Expenses before the period of insurance.
ii. Any claim caused by or arising from or due to Sickness of any and every kind

VIII. Medical Expense Reimbursement

(Available only if the schedule shows insured person opted for it)

If We have accepted a claim under I to IV hen We will reimburse the costs of necessary medical treatment the insured had to obtain from a Medical practitioner because of the Accidental Bodily Injury the insured met with. However, our payment will be limited to **40% of the value of the claim**

We accepted under I to IV or 10% of the 'Capital Sum Insured' or Rs. 5 Lac or the Actual Amount whichever is lower.

Please note that if Insured Person have opted for both VII and VIII, then the cover VIII - Medical Expense Reimbursement will be operative first and then if required, the claim could be claimed in the cover VII - Accidental Hospitalisation Cover.

IX. Modification of Residential Accommodation and Vehicle

(Available only if the schedule shows insured person opted for it)

In the event of Injury, We will reimburse up to the Sum Insured for covered expenses reasonably incurred to modify the Insured Person's residential accommodation and/or own vehicle on account of the Insured having suffered Permanent Total Disability subject to the condition that these alterations are necessary as per the advice of treating/ attending Medical Practitioner. Benefit under this section is payable subject to the claim under Permanent Total Disability under the policy becoming admissible. The maximum limit under this section will be Rs. 50,000/- for modification of single residential accommodation / vehicle.

X. Terrorism

(Available only if the schedule shows insured person opted for it)

Means activities against persons, organizations or property of any nature:

1. That involve the following or preparation for the following:
   a) Use or threat of force or violence; or
   b) Commission or threat of a dangerous act; or
   c) Commission or threat of an act that interferes with or disrupts an electronic, communication, information or mechanical system; and

2. When one or both of the following applies:
   a) The effect is to intimidate or coerce a government or the civilian population or any segment thereof, or to disrupt any segment of the economy; or
   b) It appears that the intent is to intimidate or coerce a government, or to further political, ideological, religious, social or economic objectives or to express (or express opposition to) a philosophy or ideology.

2. WORDS, PHRASES WITH SPECIAL MEANINGS

The words and phrases listed have special meanings We have set below whenever they appear in this Policy in bold type and initial Capitals. Please note that references to the singular or to the masculine also include references to the plural or to the female the context permits and if appropriate.

1. Optional Riders

The benefit under the section VI - Hospital Confinement Allowance, VII Accidental Hospitalisation Cover, VIII Medical Expense Reimbursement, and IX Modification of Residential Accommodation and Vehicle and X Terrorism are optional riders cover and would be available only if the schedule shows insured person named in the schedule has opted and has paid premium for any of such Optional Riders.

2. Capital Sum Insured

Means the amount stated in the policy schedules such or limited to the specific insurance details in any section of the policy. The capital sum insured shall be subject at all time to the

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terms and conditions of the policy, including but not limited to the exclusions and any additional limitations noted in the wording of each section.

3. Civil War

means war, whether declared or not, or any warlike activities, including use of military force by any sovereign nation to achieve economic, geographic, nationalistic, political, racial, religious or other ends.

4. Dependent child

means a child (natural or legally adopted), who is financially dependent on the primary insured or proposer and does not have his/her independent source of income. Further, the age of the child must be between 3 months to 25 years and who shall be unmarried and financially dependant.

5. Domiciliary Hospitalisation

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:

- the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
- the patient takes treatment at home on account of non availability of room in a hospital.

6. Family

Family means self, spouse, dependent children and dependent parents.

7. Insured

means the Individual, organization, institution, firm, society or body corporate engaged in any trade or business in India on whose name the policy is issued.

8. Insured Person

means and includes the persons named in the Schedule to the Policy, who have a permanent place of residence in India and for whom the insurance is proposed and appropriate premium paid.

9. Insured Event

means an event, loss or damage for which the Insured/Insured Person is entitled to benefit/s under the Policy.

10. Limit of indemnity

Limit of Indemnity represents Our maximum liability to make payment for each and every claim per person and collectively for all persons mentioned in the Schedule during the policy period and in the aggregate for the person(s) named in the schedule during the policy period, and means the amount stated in the Schedule against each Cover and subject to the limits specified in **the Section 3 - Coverage**.

11. Permanent total Disability

A disability condition certified by Civil Surgeon of Government Hospital stating the continuous and permanent:

- loss of the sight
- Loss of hands or feet
- loss of hearing
- loss of Speech

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12. Permanent Partial Disability

A disability condition certified by Civil Surgeon of Government Hospital stating the total and continuous loss or impairment of a body part or sensory organ, with the percentage of disability

13. Temporary Total Disablement:

The bodily injury that prevents you from engaging in your occupation for a period not exceeding 100 weeks since the date of injury to the time you are fit enough to resume your occupation as certified by Medical Professional.

14. Policy

Policy document is a legal document which is an evidence of the contract of Insurance between the Proposer/Insured and the Insurer and inter alia, includes the Proposal Form, Declaration Form, the Policy Schedule, Company's covering letter to the Insured, any enrolment forms, endorsements, papers or riders attaching to or forming part hereof, issued either at the inception or during the Policy Period.

15. Policy Period/Period of Insurance

The period between and including the start and end dates shown in the schedule

16. Proposal and Declaration Form

The proposal form and other information and documentation supplied to us in considering whether and on what terms to offer this insurance

17. Reasonable and Customary Charges

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.

18. Room Rent

Room Rent means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.

19. Schedule

Means Schedule attached to and forming part of this Policy mentioning the details of the Insured/ Insured Persons, the Sum Insured, the period, coverage and the limits to which benefits under the Policy are subject to.

20. Sum Insured

Means the sum as specified in the Schedule to this Policy against the name of the Insured Person, which sum represents the Our maximum liability for any or all claims under this Policy during the Policy period against the respective benefit(s) for which the sum is mentioned in the Schedule to this Policy.

21. Basic Plan

This cover is available only if the schedule shows insured person named in the schedule has opted for Basic Plan.

Under this cover, the benefits available to Insured Person/ Insured Person's family members are covered under the sections:

I.Accidental Death

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V.1. Transportation of Mortal Remains

V.2. Children‘s Education Benefit

22. Basic Plus Plan

This cover is available only if the schedule shows insured person named in the schedule has opted for Basic Plus Plan.

Under this cover, the benefits available to Insured Person/ Insured Person’s family members are covered under the sections:

I. Accidental Death

V.1. Transportation of Mortal Remains

V.2. Children‘s Education Benefit

II.Permanent Total Disability

23. Advance Plan

This cover is available only if the schedule shows insured person named in the schedule has opted for Advance Plan.

Under this cover, the benefits available to Insured Person/ Insured Person’s family members are covered under the sections:

I. Accidental Death

V.1. Transportation of Mortal Remains

V.2. Children‘s Education Benefit

II.Permanent Total Disability

III.Permanent Partial Disability

24. Comprehensive Cover

This cover is available only if the schedule shows insured person named in the schedule has opted for Comprehensive Cover.

Under this cover, the benefits available to Insured Person/ Insured Person’s family members are covered under the sections:

I. Accidental Death

V.1. Transportation of Mortal Remains

V.2. Children‘s Education Benefit

II.Permanent Total Disability

III.Permanent Partial Disability

IV.Temporary Total Disability

3. CLASSIFICATION OF RISKS

Based on your occupation/profession, you will be classified into any one of the following risk categories.

3.1 Risk Group I (Low Risk)

Accountants, Doctors, Lawyers, Architects, Consulting Engineers, Teachers, Bankers, persons engaged in administrative functions.

3.2 Risk Group II (Medium Risk)

Builders, Contractors and Engineers engaged in superintending functions only, Veterinary Doctors, paid drivers of motor cars and light motor vehicles.

All persons engaged in manual labour (Except those falling under Group III) Cash Carrying Employees, Garage and Motor Mechanics, Machine Operators, Drivers of trucks or Lorries and other heavy vehicles, Professional Athletes and Sportsmen, Woodworking Machinists.

3.3 Risk Group III (Heavy Risk)

Persons working in underground mines, explosives magazines, and workers involved in electrical installation with high tension supply, Jockeys, Circus personnel, Persons engaged in activities like racing on wheels or horseback, big game hunting, Mountaineering, winter sports, skiing, ice hockey, hang gliding, river rafting, polo.

4. WHAT IS NOT COVERED(EXCLUSIONS):

We will not pay for any event that arises because of, is caused by, or can in anyway be linked to any of the following.

4.1. Accidental Bodily Injury resulting in Death, Injury or Disablement that insured person named in the schedule meet with:

- 4.1.1 Through suicide, attempted suicide or self inflicted injury or illness.
- 4.1.2 While under the influence of liquor or drugs.
- 4.1.3 Arising or resulting from the insured person committing any breach of law with criminal intent.
- 4.1.4 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.
- 4.1.5 Whilst participating as the driver, co-driver or passenger of a motor vehicle during motor racing or trail runs.
- 4.1.6 As a result of any curative treatments or interventions that insured person carry out or have carried out on insured person body.
- 4.1.7 Arising out of insured person participation in any naval, military or air force operations whether in the form of military exercises or war games or actual engagement with the enemy, whether foreign or domestic.

4.2. Consequential losses of any kind or actual or alleged legal liability.

4.3. Any injury/disablement/death directly or indirectly arising out of or contributed to any pre-existing condition. Any Pre- existing condition shall be covered after 48 months.

4.4. Directly or Indirectly caused by Venereal or Sexually transmitted diseases

4.5. HIV (Human Immunodeficiency Virus) and/or any HIV related illness including AIDS (Acquired Immune Deficiency Syndrome) and/ or mutant derivatives or variations thereof however caused.

4.6. Pregnancy, resulting childbirth, miscarriage, abortion, or complications arising out of any of these.

4.7. Payment of compensation in respect of Accidental Death, Injury or Disablement of the Insured person 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 confiscation or nationalisation or requisition of or damage by or under the order of any government or public local authority.

4.8. Nuclear energy, radiation.

4.9. Terrorism unless specifically covered on payment of optional premium.

5. CONDITIONS

5.1 Reasonable Care

The Insured/Insured Person shall take all reasonable steps to safeguard the interests of the Insured /Insured Person against accidental loss or damage that may give rise to a claim.

5.2 Observance of Terms and Conditions

The due observance and fulfillment of the terms, conditions and endorsements of this Policy in so far as they relate to anything to be done or complied with by the Insured / Insured Person, shall be a condition precedent to any liability of the Company to make any payment under this Policy.

5.3 Material Change

The Insured/ Insured Person shall immediately notify the Company by fax or in writing of any material change in the risk or change in business or occupation and cause at his own expense such additional precaution to be taken as circumstances may require to ensure safety thereby containing the circumstances that may give rise to a claim and the Company may adjust the scope of the cover and/or the premium, if necessary, accordingly.

All cover under this Policy shall cease if any alteration be made whereby the risk of damage or injury is increased unless such alteration be agreed to by the Company in writing.

5.4 Fraudulent Claims

If any claim 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 /Insured Person or anyone acting on his/her/their behalf to obtain any benefits under the Policy, all benefits under this Policy shall be forfeited. The Company will have the right to reclaim all benefits paid in respect of a claim which is fraudulent as mentioned above under this Condition.

5.5 No Constructive Notice

Any knowledge or information of any circumstances or condition in connection with the Insured / Insured Person, in possession of any official of the Company shall not be the notice to or be held to bind or prejudicially affect the Company notwithstanding subsequent acceptance of the premium.

5.6 Notice of Charge

The Company shall not be bound to take notice of any trust, charge, lien, assignment or other dealing with or relating to this Policy; but the payment by the Company to the insured or his legal representative of any compensation or benefit under the policy shall in all cases be an effectual discharge to the Company. Also the receipt of the Insured / Insured Person, his/her nominee or legal representatives shall in all cases be a full, valid and effectual discharge to the Company.

5.7 Special Provisions

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

5.8 Overriding Effect

The terms and conditions contained herein and in the Schedule hereto shall be deemed to form part of the Policy and shall be read as if they are specifically incorporated herein.

5.9 Electronic Transaction

The Insured /Insured Person agree to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time. However, the terms of this condition shall not override provisions of any law(s) or statutory regulations including provisions of IRDA regulations for protection of policyholder's interests 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. However, the terms of this condition shall not override provisions of any law(s) or statutory regulations including provisions of IRDA regulations for protection of policyholder's interests.

5.10 Duty of the Insured / Insured Person on Occurrence of Loss

On the occurrence of loss within the scope of cover under the Policy, the Insured / Insured Person shall:

i. give written notice with full particulars to the Company immediately. In case of accidental death written notice of the death must, unless reasonable cause is shown, be so given before internment / cremation, and in any case, within one calendar month after the death, and in the event of loss of sight or amputation of limb(s), written notice thereof must be given within one calendar month after such loss of sight or amputation
ii. proof satisfactory to the Company shall be furnished on all matters upon which a claim is based
iii. in the event of death, to make a post-mortem examination of the body of the Insured Person. Such evidence as the Company may from time to time require shall be furnished within the space of fourteen days after demand in writing.
iv. in the event of a claim in respect of loss of sight the Insured Person shall undergo at the Insured's expense such operation or treatment as the Company may reasonably deem desirable
v. any Medical or other agent of the Company shall be allowed to examine the Insured Person on the occasion of any alleged injury or disablement when and so often as the same may reasonably be required on behalf of the Company
vi. allow the Medical Practitioner or any agent of the Company to inspect the medical and hospitalisation records and to examine the Insured/Insured Person
vii. assist and not hinder or prevent the Company or any of its agents in pursuance of their duties

In case the Insured / Insured Person does not comply with the provisions of this clause or other obligations cast upon the Insured / Insured Person under this Policy or in any of the Policy documents, all benefit under the Policy shall be forfeited, at the option of the Company.

5.11 Claim Documentation

The Insured / Insured Person, his/her nominee or the legal representative as the case may be, is required to submit the following documents while lodging a claim under the Policy:

In case of Personal Accident Death claims

a. FIR from police authorities wherever necessary (in case of accidents outside residence)
b. Death Certificate from the Municipal Authorities
c. Post Mortem Report
d. Any other document as may be required by the

Company In case of Personal Accident Disability

claims

a. FIR from police authorities wherever necessary (in case of accidents outside residence)
b. Medical Certificate from the attending Medical Practitioner for the injury indicating the extent of disability
c. Hospital Medical Records
d. Any other document as may be required by the Company The Insured / Insured Person shall forward to the Company forthwith every written notice or information of any verbal notice of claim and shall send to the Company any writ, summons or other legal process issued or commenced against the Insured / Insured Person and shall give all necessary information and assistance to enable the Company to settle or resist any claim or to institute proceedings. The Insured / Insured Person shall not incur any expenses in making good any claim without the written consent of the Company and shall not negotiate, pay, settle, admit or repudiate any claim without such consent

5.12 Right to Inspect

If required by the Company, an agent/representative of the Company including a Physician appointed in that behalf shall in case of any loss or any circumstances that have given rise to a claim to the Insured/Insured Person be permitted at all reasonable times to examine into the circumstances of such loss. The Insured /Insured Person shall on being required so to do by the Company produce all relevant documents relating to or containing reference relating to the loss or such circumstance in his/her possession including presenting himself for examination and furnish copies of or extracts from such of them as may be required by the Company so far as they relate to such claims or will in any way assist the Company to ascertain the correctness thereof or the liability of the Company under this Policy.

5.13 Position After a Claim

All sums payable hereunder shall be payable in the case of –

i. Accidental death or permanent total disablement, only after deleting by an endorsement the name of the Insured Person in respect of whom such sum shall become payable without any refund of premium;
ii. permanent partial disablement, only after reduction of Capital Sum Insured, by an endorsement, by the amount admissible under the claim in respect of the Insured Person in respect of whom such sum shall become payable; and
iii. temporary total disablement upon termination of such disablement

5.14 Forfeiture of Claims

If any claim is made and rejected and no court action or suit commenced within 12 months after such rejection or, in case of arbitration taking place as provided herein, within 12 calendar months after the Arbitrator or Arbitrators have made their award, all benefits under this Policy shall be forfeited.

5.15 Currency of Payment

All claims shall be payable in India in Indian Rupees only. No sum payable under this Policy shall carry interest.

5.16 Arbitration clause

If any dispute or difference shall arise as to the quantum to be paid under this 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 thereto 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 hereinbefore 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 the award by such arbitrator/arbitrators of the amount of the loss or damage shall be first obtained.

5.17 Grace Period:

Grace period means the specified period (30 days) 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.

5.18 Renewal

This Policy may be renewed by mutual consent every year and in such event, the renewal premium shall be paid to Us on or before the date of expiry of the Policy or of the subsequent renewal thereof. However We shall not be bound to give notice that such renewal premium is due.

5.19 Cancellation

We may at any time cancel the Policy on grounds of misrepresentation, fraud, non-disclosure of material fact by sending notice in writing by Registered A/D to Insured Person at Insured Person'slast known address at least 15 days in advance in which case We shall refund pro-rata premium for the unexpired portion of the policy on the date of cancellation, provided no claim has occurred up to the date of cancellation.

The Insured may also give 15 days" notices in writing, to the Company, for the cancellation of this policy, in which case the Company shall retain the premium for the period this Policy has been in force at the Company's shortperiod scales.

Period on risk	% of Annual Premium refunded		
	1 Year Policy	2 Year Policy	3 Year Policy
Upto 1 month	70%	75%	80%
Exceeding 1 month and upto 3 months	55%	70%	70%
Exceeding 3 months and upto 6 months	30%	55%	65%
Exceeding 6 months and upto 12 months	NIL	30%	45%
Exceeding 12 months and upto 18 months		10%	30%
Exceeding 18 months and upto 24 months		NIL	10%
Exceeding 24 months and upto 30 months			5%
Exceeding 30 months			NIL

i. Insurance in respect of an Insured Person shall immediately terminate at the earliest of the following dates:
   a) The date that the Policy is terminated;
   b) The date that the Capital Sum Insured is paid for covered loss

ii. In the event that the initial premium payable is not paid and realised, this Policy shall be deemed to be void from the intended Policy Effective Date.

5.20 Revision/ Modification of the policy

There is a possibility of revision/ modification of terms, conditions, coverage's and/or premiums of this product at any time in future, with appropriate approval from IRDAI. In such an event of revision/modification of the product, intimation shall be set out to all the existing insured members at least 3 months prior to the date of such revision/modification comes into the effect.

Shriram General Insurance Co. Ltd.

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Website: www.shriramgi.com, E-mail: customer.feedback@shriramgi.in
Toll Free: 1800-103-3009, 1800-300-30000, ISO/IEC 27001:2013 certified

5.21 Change in Nomination

The insured can change the nominee to whom such payment is to be made at any time during the Policy Period, provided that such change shall only be effective when the insured has notified us and We have recorded the change by an endorsement to this effect.

5.22 Territorial Limits

i. This policy cover Accidental Bodily Injury sustained during the Policy Period anywhere in the world except the above Accidental Hospitalisation Cover and Medical Expenses subject to the travel and other restrictions that the Indian Government may impose), but We will only make payment within India and in Indian Rupees.

ii. For Accidental Hospitalisation claim, the hospitalisation expenses incurred only in India would be covered and We shall make payment in Indian Rupees only.

5.23 Payment of Interest

In the event the claim is not settled within 30 days we will be liable to pay interest at a rate, which is 2% above the bank rate or regulatory provisions applicable from the date of receipt of last relevant and necessary document from the insured/ claimant by us till the date of actual payment

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Section V : Optional Cover - Loss of Employment and Loss of Job

1. Loss of employment

This Section covers the Insured up to the maximum of 3 EMI towards loan amount or lesser specified in the Schedule against default in payment of his / her loan EMIs due to loss of employment on account of:

a. Termination of the Insured from employment on account of closure of the firm / body corporate / establishment wherein the Insured is employed, due to poor financial health or any merger/acquisition of the firm / body corporate / establishment leading to the termination, dismissal or retrenchment of the Insured.
b. Termination or dismissal, lay off, temporary suspension or retrenchment of the Insured from the employment imposed on him/her by the firm / body corporate / establishment in compliance with any law relating to the employment for the time being in force or any directives by any Public Authority.
c. Any retirement scheme of compulsory nature if the firm / body corporate / establishment are closing down one division and a minimum of 20 employees are availing the retirement scheme.

The Sum Insured under this Section is limited to the number of loan EMIs as opted by the Insured or the outstanding loan amount whichever is lower at the time of claim.

Special Condition

Eligibility for claim under this Section:

- The Insured shall be out of his current job on account of the reasons mentioned herein above and shall be out of any job at least for thirty days consecutively from the time of losing his / her current job.
- The benefit under this Section will stop once he / she get another job.
- In case of joint borrowers coverage under this Section will be available to that person whose name appears first among the joint borrowers.

What is not covered?

The Company shall not be liable under this Section for

i. In the event of termination, dismissal, temporary suspension or retrenchment from employment of the Insured which is being attributed to any dishonesty or fraud on the part of the Insured or his wilful violation of any rules of the employer or laws for the time being in force.
ii. In connection with or in respect of:
    a. Self-employed persons
    b. Any claim relating to unemployment in respect of a job which is casual, temporary, seasonal orcontractual in nature.
    c. Unemployment at the time of inception of the period of insurance or arising within first three months ofinception of the period of Insurance.
iii. Termination, dismissal, temporary suspension or retrenchment from employment of the Insured which does not commence during the period of insurance.
iv. Termination, dismissal, temporary suspension or retrenchment from employment of the Insured which is less than a period of thirty (30) days at a stretch.
v. Termination, dismissal, temporary suspension or retrenchment from employment of the Insured which is attributed to poor performance of the Insured.
vi. Termination, dismissal, temporary suspension or retrenchment from employment of the Insured where insured was aware of the circumstance leading to such termination, dismissal, temporary suspension or retrenchment beforehand at the time proposing for this insurance.
vii. Unemployment of the Insured that is purely voluntary.
viii. Resignation, Superannuation, early retirement of the Insured.

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2. Loss of Earning (Professional / Business People)

If insured is not able to earn his usual income and has become nil due to any of the following reason/s, the policy will pay a maximum of 3 EMI towards loan amount or lesser if insured get start earning earlier. Insured need to establish his/her loss earnings by suitable documental evidence

1. Serious injury making insured person immobile
2. Serious illness making insured person immobile
3. Loss/ damage to working place due to fire and allied perils
4. Due to inability to access working place (due to operation Act of God peril)

3. Definitions

1. **Bank / Financial Institution -** Means a banking company which transacts the business of banking in India or abroad and Financial Institution engaged in activity of providing loans and duly recognised by appropriate authority.
2. **Loan EMI -** Means the equated monthly instalment payable by the Insured to a financial institution for the loan.

4. Redressal Of Grievance

Welcome to Shriram General Insurance and Thank You for choosing us as your insurer.

Please read your Policy and Schedule. The Policy and Policy Schedule set out the terms of your contract with us. Please read your Policy and Policy Schedule carefully to ensure that the cover meets your needs.

We do our best to ensure that our customers are delighted with the service they receive from us. If you are dissatisfied we would like to inform you that we have a procedure for resolving issues. Please include your Policy number in any communication. This will help us deal with the issue more efficiently. If you don't have it, please call your Branch office.

First Step Initially, We suggest you to contact the Branch Manager / Regional Manager of the local office which has issued the Policy. The address and telephone number will be available in the Policy.

Second Step Naturally, We hope the issue can be resolved to your satisfaction at the earlier stage itself. But if you feel dissatisfied with the suggested resolution of the issue after contacting the local office, please e-mail or write to Grievance Cell, HO, headed by a senior executive which will be directly under the control of the MD at the below mentioned address:

Contact Person: Chief Compliance and Grievance Officer
Contact Address: Shriram General Insurance Co. Ltd.
E-8, EPIP, RIICO Industrial Area, Sitapura, Jaipur – 302022
Grievance Cell No: 1800-103-3009, 1800-300-30000
E-mail ID: md@shriramgi.com
Fax No.: 91-141-2770693
You can also reach us by email or register their complaints on the website of the Company.

In case your complaint is not fully addressed by the Company, You may use the Integrated Greivance Management System (IGMS) https://igms.irda.gov.in For registration please visit IRDAI website www.irda.gov.in.

The contact details of the ombudsman offices are mentioned below. However, We request you to visit https://www.shriramgi.com for updated details.

Grievance Redressal Cell for Senior Citizens
Our customers who are above 60 years of age we have created special cell to address any health insurance related grievances.
Our senior citizen customers can reach us through the below dedicated channels to enable us to service them promptly.
Grievance Cell No: 1800-103-3009, 1800-300-30000
Exclusive Email address: seniorcitizen@shriramgi.com
In case your complaint is not fully addressed by the Company, You may use the Integrated Greivance Management System (IGMS) https://igms.irda.gov.in For registration please visit IRDAI website www.irda.gov.in.

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The 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@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU	Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
BHOPAL	Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh, Chattisgarh.
BHUBANESHWAR	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.
CHANDIGARH	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.
CHENNAI	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Tamil Nadu Puducherry Town and Karaikal (which are part of Puducherry)
DELHI	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
GUWAHATI	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.

JAIPUR	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
ERNAKULAM	Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
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@cioins.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@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, 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@cioins.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.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal,

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		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@cioins.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@cioins.co.in	Maharashtra,Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.