Policy Document - Terms and Conditions of your policy

ICICI Pru Super Protect

This is a Non-Participating Non- Linked Life Group Pure Risk Insurance Product

PART-B

Definitions

1. Beneficiary means the insured Member or the person nominated by the Member as the recipient of the Benefits under the Rules of the Scheme. **2. Certificate of Insurance** means the certificate issued by the Company to Member to confirm the Member's insurance cover under the Master Policy. **3. Claimant** means the person(s) entitled to receive benefits as per the terms and conditions of the policy and applicable laws, and includes the Master Policyholder, the Nominee, the Member, the Assignee, the legal heir, the legal representative(s) or the holder(s) of succession certificate as the case may be. **4. Coverage Term** means the period for which insurance cover is provided to the individual Member under the Master Policy and is the period between the Date of Commencement of Cover and Terminal Date or Date of Termination of Cover; whichever is earlier **5. Benefit Coverage Term** means the period for which the benefit cover (if applicable) is provided to the individual Member under the Master Policy and is the period between the Date of Commencement of Cover and Terminal Date or Date of Termination of Benefit; whichever is earlier **6. Date of Commencement of Cover** means the date of commencement of Cover for the individual Members under the Master Policy: (i) at the time of issuance of the Master Policy, it will be the date of acceptance of risk subject to receipt of Member data and premium towards these Members. (ii) for new Members joining during the term of the Master Policy, it will be the date of acceptance of risk subject to receipt of Member data and premium towards these Members. Here, Member Data means the necessary details of the Members required to provide risk Cover. **7. Date of termination of Cover** means the date specified in the Certificate of Insurance on which the Member cover stands terminated with all rights and benefits thereunder. **8. Date of termination of Benefit** means the date specified in the Certificate of Insurance (if applicable and mentioned) on which the Members' cover for the respective Benefit stands terminated with all rights and benefits thereunder**. 9. EMI stands** for Equated Monthly Instalment and it's a fixed amount of money that a borrower pays to lender each month to repay a loan.

10. Financial Year is the period from 1st April of a calendar year to 31st of March of the subsequent calendar year. **11. Group** means a group of Members accepted by the Company as constituting a Group for the purposes of the Master Policy. **12. Hospital:** A hospital means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and the said act Or complies with all minimum criteria as under: • has qualified nursing staff under its employment round the clock; • has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places; • has qualified medical practitioner(s) in charge round the clock; • has a fully equipped operation theatre of its own where surgical procedures are carried out; • maintains daily records of patients and makes these accessible to the insurance company's authorized personnel; **13. Hospitalisation** 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. **14. Master Policy** shall mean this document, any supplementary contracts or endorsements therein, whenever executed, any amendments thereto agreed to and signed by Us, the application form provided by You, the Schemes Rules, the quotation of the Company for the Scheme and the individual enrolment forms, if any, of the insured Members, which together constitute the entire contract between the parties. **15. Medical Practitioner:** A Medical Practitioner is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license. The Medical Practitioner should neither be the insured person(s) himself nor related to the insured person(s) by blood or marriage nor share the same residence as the Member. **16. Member** is someone who is covered under the Scheme as per the Rules of the Scheme and is therefore eligible for the benefits under this Policy. **17. Member Joining Date** means the date on which a Member joins the Scheme and is covered under the Master Policy. **18. Moratorium period** means the period during which Sum Assured remains constant. **19. Other Entities** shall mean to include the entities other than Regulated Entities. **20. Policy Commencement Date** means the date as specified in the Policy Schedule, on which the insurance coverage under this Policy commences. **21. Policy Schedule** means the policy schedule and any endorsements attached to and forming part of this Policy. **22. Policy Year** is a period of 12 months starting from the Policy Commencement Date. **23. Proposal Form** means a form to be filled in by You in physical or electronic form, for furnishing the information including material information, if any, as required by Us in respect of a risk, in order to enable Us 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. Explanation: (i) "Material Information" shall mean all important, essential and relevant information and documents. **24. Regulator** is the Authority that has Regulatory jurisdiction and powers over the Company. Currently the regulator is Insurance Regulatory and Development Authority of India (IRDAI). 26. 25**. Rules or Scheme Rules or Rules of the Scheme or the Scheme** mean the rules and boundary conditions governing the grant of benefits to the Members which are framed by the Master Policyholder and accepted by the Company. These rules also cover all the Legal and Statutory obligations that the Master Policyholder undertakes to fulfil towards the Members and the Company.**Single Pay** means premium needs to be paid once at the start of the Member cover. **27. Sum Assured** means the amount specified in the Policy Schedule / Member annexure / Certificate of Insurance. **28. Surrender** means complete withdrawal or termination of the entire Master Policy contract**. 29. Surrender value** means an amount, if any, that becomes payable on surrender of a policy during its term, in accordance with the terms and conditions of the policy. **30. Terminal Date** means the date when a Member attains the maximum risk cover ceasing age or the date on which he ceases to be a Member of the Scheme whichever is earlier. **31. We** or **Us** or **Our or Company** means ICICI Prudential Life Insurance Company Limited. **32. You** or **Your** means the Master Policyholder named in the Policy Schedule.

PART-C

1. Benefits payable under Your policy

a) The benefits applicable to You as chosen by You in the Proposal Form are as mentioned in Annexure I of this policy document. b) Along with Death Benefit, other Benefits can be chosen by the Member, only at the inception of the cover, provided the Benefits have been opted for by the Master Policyholder. c) Benefits payable will depend on the Coverage option chosen and will be as set out in the Certificate of Insurance. The Benefits payable shall not vary or be otherwise determined by the loan repayments, if any, already made by the Member or the outstanding loan amount, if any, of the Member, at the occurrence of an event giving rise to a claim under the Master Policy. d) Benefits are payable only if the cover with respect to the Member is in-force and if the occurrence of an event giving rise to the claim takes place within the Member's Coverage Term. e) At the start of the Member cover, Benefit amounts are as mentioned in the Member's Certificate of Insurance. Death Benefit is equal to the Sum Assured at the start of the Member's cover. In case of Reducing Cover option, the Benefits reduce throughout the Benefit Coverage Term or remain constant during moratorium period and reduce thereafter, as set out in Member's Certificate of Insurance. In case of Level Cover option, Benefits remain constant throughout the Benefit Coverage Term. f) In case of Joint Life Coverage Option, on payment of the benefit in respect of the first claimant, cover of both the lives will cease. g) Such Benefits would be treated as per the prevailing tax laws. **I. Death Benefit** a) Death Benefit will be payable on death of the Member during the Coverage Term. b) Upon payment of Death

Benefit to the Claimant, the Member's cover will terminate and all rights, benefits and interests of the Member under the Master Policy will stand extinguished. c) In the event of death of the Member on the Date of Termination of Cover or Terminal Date, then death benefit shall not be payable. The Member Cover shall terminate with all rights and benefits thereunder. **II. Accelerated Terminal Illness (TI) Benefit** (applicable only if opted for by the Master Policyholder) a) This benefit will be payable on diagnosis of Terminal Illness of the Member during the Benefit Coverage Term. b) TI Benefit is always equal to the Death Benefit. This is an accelerated benefit and not an additional benefit, which means payment of this benefit will not be in addition to the Death Benefit. c) Terminal Illness conditions and exclusions are applicable (refer to Part D for details). d) On payment of such benefits, the Member Policy will terminate and all rights, benefits and interests of the Member under the Master Policy will stand extinguished. e) In the event the Member is diagnosed with Terminal Illness on the Date of Termination of Benefit or Terminal Date, then this benefit shall not be payable. The Member Cover shall terminate with all rights and benefits thereunder. **III. Accidental Death (AD) Benefit** (applicable only if opted for by the Master Policyholder) a) In the event of the Member's death due to an accident, where accident occur during the AD Benefit Coverage Term, the AD Benefit will be payable. This is an additional benefit and will be paid in addition to the Death Benefit. b) AD Benefit can be less than or equal to the Death Benefit. c) AD Benefit conditions and exclusions are applicable (refer to Part D for details). d) On payment of such benefits, the Member's cover will terminate and all rights, benefits and interests of the Member under the Master Policy will stand extinguished. e) In the event of an accident on the Date of Termination of Benefit or Terminal Date; whichever is earlier resulting in the death of the Member, then this benefit shall not be payable. The Member Cover shall terminate with all rights and benefits thereunder. **IV. Enhanced Accidental Death (EAD) Benefit** (applicable only if opted for by the Master Policyholder) a) In the event of the Member's death due to an accident, where accident occur during the EAD Benefit Coverage Term, the EAD Benefit will be payable. If the death happens due to an accident on account of plane, train or ship, an amount double of EAD Benefit will be payable. This is an additional benefit and will be paid in addition to the Death Benefit. b) EAD Benefit can be less than or equal to the Death Benefit. c) EAD Benefit conditions and exclusions are applicable (refer to Part D for details). d) Only one of either AD Benefit or EAD Benefit can be chosen. e) On payment of such benefits, the Member's cover will terminate and all rights, benefits and interests of the Member under the Master Policy will stand extinguished. f) In the event of an accident on the Date of Termination of Benefit or Terminal Date; whichever is earlier resulting in the death of the Member, then this benefit shall not be payable. The Member Cover shall terminate with all rights and benefits thereunder. **V. Accelerated Accidental Total and Permanent Disability (ATPD) Benefit** (applicable only if opted for by the Master Policyholder) a) In the event of the Member being regarded as Totally and Permanently Disabled due to an accident during the ATPD Benefit Coverage Term, the ATPD Benefit will be payable. b) ATPD Benefit can be less than or equal to the Death Benefit. This is an accelerated benefit and not an additional benefit, which means payment of this benefit will not be in addition to the Death Benefit. On payment of this benefit, Member's Death Benefit, TI Benefit (if chosen) will be reduced by the extent of the payment already made. ACI Benefit if chosen and is more than the reduced Death Benefit, ACI Benefit will decrease to the amount of reduced Death Benefit, else will remain unchanged. c) ATPD Benefit conditions and exclusions are applicable (refer to Part D for details). d) Upon payment of this benefit, the Member's ATPD Benefit will terminate. If ATPD Benefit is equal to the Death Benefit the Member's cover will terminate and all rights, benefits and interests of the Member under the Master Policy will stand extinguished. e) In the event of an accident on the Date of Termination of Benefit or Terminal Date; whichever is earlier resulting in the total and permanent disability of the Member, then this benefit shall not be payable. **VI. Cancer Protect (CP) Benefit** (applicable only if opted for by the Master Policyholder) a) CP Benefit will be payable as mentioned in the table below upon diagnosis of the listed conditions during the CP Benefit Coverage Term.

Level and covered condition	**Payout** (as % of CP Benefit)
Minor Condition: 1. Carcinoma in situ of any organ except skin 2. Early stage cancers	25%
Major Condition: Cancer of specified severity	100% less earlier Minor Condition claim payout, if any

b) In case of minor condition claim, 25% of the CP Benefit, as at the time of incidence of claim, will be payable. This is an additional Benefit. c) Claim will be admissible only if the Member is diagnosed for the first ever occurrence of any of the listed conditions. d) Multiple Minor claims will be admissible till the total payout does not exceed 100% of the CP Benefit. e) For multiple Minor conditions claims of an individual Member to be admissible, there needs to be a period of at least 6 months between the date of diagnosis of a Minor condition claim and date of diagnosis of subsequent Minor condition claim. However this requirement of 6 months is not applicable in case of diagnosis of a major condition claim following a minor condition claim. f) Multiple Minor condition claims from the same organ of the individual Member will not be admissible. For the purpose of claim, each group of the following sites are treated as one organ. • Basal cell and squamous skin cancer • Corpus uteri, vagina, fallopian tubes, cervix uteri, ovary • Colon and rectum • Penis, testis • Stomach and esophagus g) CP Benefit can be less than or equal to Death Benefit. h) CP Benefit conditions, exclusions and waiting period are applicable (refer to Part D for details). i) On payment of 100% of CP Benefit, the Member's CP Benefit will terminate. j) In the event the Member is diagnosed with a minor or major condition (Cancer) on the Date of Termination of Benefit or Terminal Date; whichever is earlier, then this benefit shall not be payable. **VII. Waiver of EMI on Hospitalisation (WoEH) Benefit:** (applicable only if opted for by the Master Policyholder) a) This benefit is payable if the Member, on the recommendation of a medical practitioner, is hospitalised for the required continuous number of days in that policy year, during the WoEH Benefit Coverage Term. The options for number of days of hospitalisation are as below: i. Minimum 7 days of continuous hospitalisation; or/and ii. Minimum 15 days of continuous hospitalisation b) The benefit can be up to a maximum of 6 EMIs. c) WoEH Benefit can be claimed once every policy year. d) WoEH Benefit conditions, exclusions and waiting period are applicable (refer to Part D for details). e) WoEH Benefit remains constant throughout the WoEH Benefit coverage term in both Reducing Cover and Level Cover options. f) Benefit is available for a maximum tenure of 5 years or the member coverage term whichever is lesser. **VIII. Accelerated Critical Illness (ACI) Benefit** (applicable only if chosen by the Master Policyholder) a) ACI Benefit will be payable on the Member being diagnosed to be suffering from a covered Critical Illness as per the Critical Illness package chosen, during the ACI Benefit Coverage Term as mentioned in the Certificate of Insurance. Any one of Essential, Classic or Comprehensive Critical Illness packages covering 7, 19 and 33 Critical Illnesses respectively can be chosen. The list of Critical Illnesses covered under these packages is given in section X below. b) Claim will be admissible only if the Member is diagnosed for the first ever occurrence of any of the covered Critical Illness. c) ACI Benefit conditions, exclusions and waiting period are applicable (refer to Part D for details). d) ACI Benefit can be less than or equal to Death Benefit. This is an accelerated benefit and not an additional benefit, which means payment through this benefit will not be in addition to the Death Benefit. On payment of this benefit, member's Death Benefit, TI Benefit (if chosen) will be reduced by the extent of the payment made. ATPD Benefit if chosen and is more than the reduced Death Benefit, ATPD Benefit will decrease to the amount of reduced Death Benefit, else will remain unchanged. e) Upon payment of ACI Benefit, Member's ACI Benefit will terminate. If ACI Benefit is equal to the Death Benefit the Member Policy will terminate and all rights, benefits and interests of the Member under the Master Policy will stand extinguished. f) Only one of ACI Benefit or Additional Critical Illness Benefit can be chosen. In the event the Member is diagnosed with any of the covered Critical Illnesses on the Date of Termination of Benefit or Terminal Date; whichever is earlier, then this benefit shall not be payable. **IX. Additional Critical Illness (CI) Benefit** (applicable only if opted for by the Master Policyholder) a) CI Benefit will be payable on the Member being diagnosed to be suffering from a covered Critical Illness from the Critical Illness package chosen, during the CI Benefit Coverage Term mentioned in the Member's Certificate of Insurance. CI Benefit will be payable only if the Member survives for a period of 14 days from the date of diagnosis of the

Critical Illness. Any one of Essential, Classic or Comprehensive Critical Illness packages covering 7, 19 and 33 Critical Illnesses respectively can be chosen. The list of Critical Illnesses covered under these packages is given in section X below. b) Claim will be admissible only if the Member is diagnosed for the first ever occurrence of any of the covered Critical Illness. c) This is an additional benefit. d) CI Benefit can be less than or equal to Death Benefit. e) CI Benefit conditions, exclusions, waiting period are applicable (refer to Part D for details). f) Upon payment of this benefit, the Member's CI Benefit cover will terminate. g) In the event the Member is diagnosed with any of the covered Critical Illnesses on the Date of Termination of Benefit or Terminal Date; whichever is earlier, then this benefit shall not be payable. **X. Critical Illnesses covered under the Essential, Classic and Comprehensive Critical Illness coverage packages**

Critical Illness Coverage Package			Sr. No.	List of Critical Illnesses covered
Comprehensive			1	Cancer of Specified Severity
			2	First Heart Attack of Specified Severity
			3	Open Chest CABG
		Essential	4	Stroke resulting in permanent symptoms
			5	Kidney Failure Requiring Regular Dialysis
			6	Major Organ/ Bone Marrow Transplant
			7	Loss of Independent Existence
			8	Blindness
			9	Multiple Sclerosis with Persisting Symptoms
	Classic		10	Alzheimer's Disease
			11	Heart Valve Surgery (Open Heart Replacement or Repair of Heart Valves)
			12	Deafness
			13	Apallic Syndrome
			14	Benign Brain Tumour
			15	Brain Surgery
			16	Coma of Specified Severity
			17	Major Head Trauma
			18	Permanent Paralysis of Limbs
			19	Major Burns
			20	Motor Neurone Disease with Permanent Symptoms
			21	Surgery to aorta
			22	Chronic Lung Disease
			23	Chronic Liver Disease
			24	Parkinson's Disease
			25	Cardiomyopathy
			26	Loss of Limbs
			27	Primary Pulmonary hypertension
			28	Loss of Speech
			29	Systematic lupus Eryth. with Renal Involvement
			30	Aplastic Anaemia
			31	Muscular Dystrophy
			32	Poliomyelitis
			33	Medullary Cystic Disease

2. Administrative convenience options

a. Single Rate facility • This facility may be selected by the Master Policyholder at Policy inception. • This facility is available for Coverage Term up to 2 years. • Upon selection of this facility, the premium rate determined at Policy inception shall be applicable for all the members joining the Group. • There is no additional fee or charge applicable for choosing this facility. b. Age Banded Rate facility • This facility may be selected by the Master Policyholder at Policy inception. • This facility is available for Coverage Term of greater than or equal to 2 years for Rural or micro groups. However, for other groups this facility is available for Coverage Term of only up to 2 years. • Upon selection of this facility, the Age banded rate determined at Policy inception shall be applicable for all Members joining the group. • There is no additional fee or charge applicable for choosing this facility. If neither of the above facility is chosen by the Master Policyholder, then age specific rates shall be applicable for all the members of the Group.

2. Eligibility for Membership

a) Persons who join the Group on or after the Policy Commencement date and avail loan shall be eligible for Membership of the Scheme, subject to them being within the age limits as specified in Rules of the Scheme. b) The eligibility of a Member to join the scheme is subject to the Company receiving an intimation of eligibility of the Member and premium amount preferably within 45 days of the Member becoming eligible. c) A Members' coverage under the Master Policy shall terminate on any of the following: i. he/she ceases to satisfy any of the eligibility criteria and he/she chooses to expressly discontinue the cover when he/she ceases to be a Member of the group; ii. Upon payment of the following Benefits by Us in respect of such Member a. Death Benefit b. Accelerated Terminal Illness Benefit c. ATPD Benefit or ACI Benefit where these benefits are equal to Death Benefit iii. he / she surrenders his / her Certificate of Insurance; iv. On expiry of Coverage Term

3. Cover of Members

a) The Master Policy provides life cover equal to the Sum Assured as specified in the Certificate of Insurance and as per the benefit and coverage options chosen, for Members of the group covered by the Master Policy. b) The Sum Assured applicable for each Member would be as specified in the Certificate of Insurance of each member. We would cover the Member subject to underwriting. Sum Assured shall also be consistent with the original loan amount sanctioned for level cover or with the loan schedule at inception. c) The Master Policyholder shall hold this Master Policy of ICICI Pru Super Protect - Credit (referred to in this document as "the Policy" or "the Master Policy"). d) All Benefits arising out of the Master Policy shall be solely for the Benefit of the Members. e) The Company will pay the Benefit on occurrence of an event upon which the Benefit becomes payable, and only on receipt of documents authenticated by the Master Policyholder, and to the satisfaction of the Company. f) The Members shall nominate beneficiary(ies) to receive the benefits under the Master Policy whose details shall be furnished to Us. g) The Cover under the Master Policy shall be effective for the Coverage Term/ Benefit Coverage Term. A Member shall be entitled to the applicable Benefits of the Master Policy from the Date of Commencement of Cover up to his Terminal Date or Date of termination of Cover or Date

of Termination of Benefit whichever is earlier, subject to him/her being a Member.

4. Method of effecting Cover:

For effecting the Cover to the Member under the Master Policy: a) The Master Policyholder / Member shall immediately make available to the Company all such original documents and the premium payable for effecting Cover to the Member of the Master Policy. b) Cover will commence only if the personal statement / declaration of good health, if any, or any other factor relating to the insurability of a life is to the satisfaction of the Company. The decision of the Company thereon shall be final and binding on the Master Policyholder and the Member. c) This Master Policy has been effected in accordance with the Rules of the Scheme. Any amendment of the Rules of the Scheme by the Master Policyholder shall be operative, only, if the amendment is specifically approved by the Company in writing and not otherwise. d) We shall have the right to vary the terms and conditions of the Master Policy including the premium payable or to discontinue adding new Members to the Master Policy, by giving a written notice of one month.

5. Premium payment

a) Separate premiums are required to be paid in respect of every individual Member under the Master Policy. b) Premiums are required to be paid once at the start of the Member cover. c) Premium may be paid through any of the following modes: a. Cheque b. Demand Draft c. Pay Order d. Banker's cheque e. Internet facility as approved by the Company from time to time f. Electronic Clearing System / Direct Debit g. Credit or Debit cards held in your name d) Amount and modalities will be subject to our rules and relevant legislation or regulation e) In case the payment made towards the premium for the Members are not realized by Us due to any reason whatsoever You shall be solely responsible for the verification of such realisation. f) In case the payment made towards the Premium or premium for Members are not realised by us due to any reason whatsoever, the Policy or the Member Policy as applicable, if issued, shall stand automatically cancelled and the cover of the Members shall be terminated.

6. Maturity benefit

There is no maturity benefit payable under the product.

PART-D

1. Free look Period

On receipt of the Policy Document/Certificate of Insurance, whether received electronically or otherwise, You/Member have an option to review the policy terms and conditions . If You/Member are not satisfied or have any disagreement with the terms and conditions of the policy/Member Policy or otherwise and have not made any claim, the Policy Document/Certificate of Insurance needs to be returned to the Company with reasons for cancellation within 30 days from the date of receipt of the Policy Document On cancellation of the Policy / Member's cover during the free look period, We will return the premium paid subject to the following deductions: i. Stamp duty paid under the policy, if any ii. Expenses borne by the Company on medical examination, if any iii. Proportionate risk premium for the period of cover The Policy / Member's cover shall terminate on payment of this amount and all rights, benefits and interests will stand extinguished.

2. Surrender Value

In case of surrender of the Master Policy by the Master Policyholder or foreclosure of loan by the insured Member or transfer of loan to another company by the insured Members, the Members shall have an option to continue the cover till the end of the coverage Term. Such Cover shall continue with the same terms and conditions as the original cover. If the member decides to continue the cover then the same has to be intimated to the Company either by the Member or by the Master policyholder. For Members who opt to Surrender their cover or do not choose to continue the cover upon (a). Surrender of the Master Policy by the Master Policyholder; or (b). foreclosure of the loan or transfer of loan to another company by the Members, then the Surrender value equal to unexpired risk premium value shall be payable by the Company. Surrender value for the member's cover will be the sum of Benefit Surrender Value for each of the chosen benefit. Benefit Surrender Value = 60% x Single Premium of a benefit x [Unexpired coverage term of the benefit (in complete months) / Original coverage term of the benefit (in complete months)] x [(Current Benefit Amount / Original Benefit Amount)] Where, Original Benefit Amount is the Benefit amount specified for the member at inception. For Reducing Cover, Current Benefit Amount is the Benefit Amount applicable in the month of surrender as per the reduction schedule set at inception. For Level Cover, Current Benefit Amount is equal to original Benefit Amount .On payment of Surrender Value, the Member's cover for all Benefits will terminate and all rights, benefits and interests of the Member under the Policy will stand extinguished.

3. Policyholder Covenants

The Master Policyholder agrees to apply its prescribed norms and procedures for assessing all loan applications and apply its stipulated credit recovery procedures thereon, regardless of whether or not cover is sought on the lives of its borrowers. The Insurer reserves with it the right to call for the guidelines of the Policyholder's credit criteria at any time, and the Policyholder shall supply the same to the Insurer within the time limits if any specified therein. The Policyholder (or any of its affiliated organization / entity) in its capacity as Group Organizer / Group Manager, with whatsoever nomenclature may be, is prohibited from collecting any amount other than the insurance premium payable to the Insurers with regard to the underlying Group Insurance. Policyholder shall collect the duly valid and complete Declaration of Good Health (Evidence of Good Health) along with such other documents as it may require for the purpose of the loan given to the member. The Policyholder shall preserve and maintain it as an integral part of such loan documentation. The Policyholder shall allow the officers of the Insurer (including representatives authorized in writing by the Insurer), to inspect and make copies of all/any relevant records for the purposes of this Policy, at reasonable hours on any day. It shall be the duty of the Policyholder to ensure that the Declaration of Good Health is duly filled in and signed by the member. In case a claim is settled by the insurer on a member's life, which would not have been covered under the Policy due to incomplete Declaration of Good Health submitted by the Policyholder, then the Policyholder shall indemnify the Insurer to the extent of the claim amount/payments made on such lives. In accordance to the IRDA circular ref 015/IRDA/Life/Circular/GI Guidelines/2005 dated July 14, 2005, the Policyholder shall obtain a Certificate of compliance from the Auditor of the group or the Manager of the group on every anniversary date of the Policy and submit the same to the Insurer at its request. Continuation of such Policy / cover will be subject to such submission of Certificate of compliance by the Policyholder to the Insurer. Or alternatively, the Insurer shall conduct the inspection of the books and records of the Policyholder to assess whether they are complying with the relevant IRDA guidelines.

4. Definitions, Conditions and Exclusions

I. Suicide If a Member, whether sane or insane, commits suicide within one year from the date of commencement of cover, while the cover is in-force, 80% of Premium Paid, in respect of such a Member will be payable. On the above payment, the Member's cover will terminate and all rights, benefits and interests of the Member under the Master Policy will stand extinguished. In case of Joint Life cover, this clause is applicable on either of the Members committing suicide. Post payment of the applicable amount, both the members' cover will terminate and all rights, benefits and interests of both members will stand extinguished. **II. For Accelerated Terminal Illness Benefit following conditions apply (only if TI Benefit is chosen by the Master Policyholder).** A member shall be regarded as Terminally Ill only if that member is diagnosed as suffering from a condition which, in the opinion of two independent medical practitioners specializing in treatment of such illness, is highly likely to lead to death within 6 months. The Terminal Illness must be diagnosed and confirmed by independent medical practitioners registered with the Indian Medical Association and approved by the Company. The Company reserves the right for independent assessment. The definition of medical practitioner will be as given below: "A Medical Practitioner is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license. The Medical Practitioner should neither be the insured person(s) himself nor related to the insured person(s) by blood or marriage nor share the same residence as the Member ." **III. For Accidental Death Benefit / Enhanced Accidental Death Benefit the following Conditions and Exclusions apply (only if AD Benefit/ EAD Benefit is chosen by the Master Policyholder):** We will not be liable to pay the Accidental Death Benefit/ Enhanced Accidental Death Benefit if the

Accident is directly or indirectly due to or caused, occasioned, accelerated or aggravated by, any one of the following:

1. Death due to accident should not be caused by the following:
a) Attempted suicide or self-inflicted injuries while sane or insane, or whilst the Member is under the influence of any narcotic substance or drug or intoxicating liquor except under the direction of a medical practitioner; or b) Engaging in aerial flights (including parachuting and skydiving) other than as a fare paying passenger or crew on a licensed passenger-carrying commercial aircraft operating on a regular scheduled route; or c) The Member with criminal intent, committing any breach of law; or d) Due to war, whether declared or not, or civil commotion; or e) Engaging in hazardous sports or pastimes, e.g. taking part in (or practicing for) boxing, caving, climbing, horse racing, jet skiing, martial arts, mountaineering, off piste skiing, pot holing, power boat racing, underwater diving, yacht racing or any race, trial or timed motor sport.

2. Death is caused due to an accident, wherein an accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.

3. The accident shall result in bodily injury or injuries to the Member independently of any other means. Such injury or injuries shall, within 180 days of the occurrence of the accident, directly and independently of any other means cause the death of the Member. In the event of the death of the Member after 180 days of the occurrence of the accident, the Company shall not be liable to pay this benefit. The benefit is payable if the Accidental Death occurs beyond the Benefit Coverage Term but within 180 days from the date of Accident, provided the Accident occurs within the Benefit Coverage Term.

4. Train accident will be as per Section 124 of the Indian Railways Act, mentioned below
"When in the course of working a railway, an accident occurs, being either a collision between trains of which one is a train carrying passengers or the derailment of or other accident to a train or any part of a train carrying passengers, then whether or not there has been any wrongful act, neglect or default on the part of the railway administration such as would entitle a passenger who has been injured or has suffered a loss to maintain an action and recover damages in respect thereof, the railway administration shall, notwithstanding anything contained in any other law, be liable to pay compensation to such extent as may be prescribed and to that extent only for loss occasioned by the death of a passenger dying as a result of such accident, and for personal injury and loss, destruction, damage or deterioration of goods owned by the passenger and accompanying him in his compartment or on the train, sustained as a result of such accident."

5. The member's cover must be in-force at the time of accident.

6. The Company shall not be liable to pay this benefit in case the accident that resulted in the accidental death of the Member occurs on or after the Date of Termination of the Benefit cover.

7. Exclusions for AD Benefit will only apply to AD Benefit and death benefit will be paid on death due to accident.

IV. For Accelerated Accidental Total and Permanent Disability Benefit the following conditions and exclusions apply (only if ATPD Benefit is chosen by the Master Policyholder) Accidental Total and Permanent Disability (ATPD) Benefit will be payable if the Member has become totally and irreversibly disabled as a result of accident. It includes:

1. The total and permanent loss of use of both hands, or both feet, or both eyes, or a combination of any two, will also result in the Member being regarded as totally and permanently disabled, or,

2. To be regarded as totally and permanently disabled, the Member must be totally incapable of being employed or engaged in any work or any occupation whatsoever for remuneration or profit, or,

3. To be regarded as totally and permanently disabled, the Member must be unable to perform (whether aided or unaided) at least 3 of the following 6 "Activities of Daily Work"
a) Mobility: The ability to walk a distance of 200 meters on flat ground. b) Bending: The ability to bend or kneel to touch the floor and straighten up again and the ability to get into a standard saloon car, and out again. c) Climbing: The ability to climb up a flight of 12 stairs and down again, using the handrail if needed. d) Lifting: The ability to pick up an object weighing 2kg at table height and hold for 60 seconds before replacing the object on the table. e) Writing: The manual dexterity to write legibly using a pen or pencil, or type using a desktop personal computer keyboard. f) Blindness – permanent and irreversible - Permanent and irreversible loss of sight to the extent that even when tested with the use of visual aids, vision is measured at 3/60 or worse in the better eye using a Snellen eye chart.

4. The disability should have lasted for at least 180 days without interruption and must be deemed permanent by a Company empanelled medical practitioner.

5. TPD due to accident should not be caused by the following:
a) Attempted suicide or self-inflicted injuries while sane or insane, or whilst the Member is under the influence of any narcotic substance or drug or intoxicating liquor except under the direction of a medical practitioner; or b) Engaging in aerial flights (including parachuting and skydiving) other than as a fare paying passenger or crew on a licensed passenger-carrying commercial aircraft operating on a regular scheduled route; or c) The Member with criminal intent, committing any breach of law; or d) Due to war, whether declared or not or civil commotion; or e) Engaging in hazardous sports or pastimes, e.g. taking part in (or practicing for) boxing, caving, climbing, horse racing, jet skiing, martial arts, mountaineering, off piste skiing, pot holing, power boat racing, underwater diving, yacht racing or any race, trial or timed motor sport.

6. TPD due to accident, wherein accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.
a. The accident shall result in bodily injury or injuries to the Member independently of any other means. Such injury or injuries shall, within 180 days of the occurrence of the accident, directly and independently of any other means cause the TPD of the Member. In the event of TPD of the Member after 180 days of the occurrence of the accident, the Company shall not be liable to pay this benefit. The benefit is payable even if the ATPD occurs beyond the Benefit Coverage Term but within 180 days from the date of Accident, provided the Accident occurs within the Benefit Coverage Term, and the disability should have lasted for at least 180 days without interruption and must be deemed permanent by a Company empanelled medical practitioner

7. The member's cover must be in-force at the time of accident.

8. The Company shall not be liable to pay this benefit in case the accident that resulted in TPD of the Member occurs on or after the Date of Termination of the Benefit cover.

V. For Accelerated Critical Illness Benefit and Additional Critical Illness Benefit the following definitions apply (only if ACI Benefit or CI Benefit is chosen by the Master Policyholder)

1. Cancer of Specified Severity:
A malignant tumour characterised by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma. The following are excluded –

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

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

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

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

5. All Thyroid cancers histologically classified as T1N0M0 (TNM classification) or below;

6. Chronic lymphocytic leukaemia less than RAI stage 3;

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

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

2. First Heart Attack of Specified Severity:

The first occurrence of myocardial infarction which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria: a) A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain) b) New characteristic electrocardiogram changes c) Elevation of infarction specific enzymes, Troponins or other specific biochemical markers. The following are excluded: a) Other acute Coronary Syndromes b) Any type of angina pectoris. c) A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. Open Chest CABG:

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

4. Stroke resulting in permanent symptoms

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced. The following are excluded: • Transient ischemic attacks (TIA) • Traumatic injury of the brain • Vascular disease affecting only the eye or optic nerve or vestibular functions.

5. Kidney Failure Requiring Regular Dialysis:

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

6. Major Organ/ Bone Marrow Transplant

The actual undergoing of a transplant of:

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

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

3. The following are excluded:

a. Other stem-cell transplants b. Where only islets of langerhans are transplanted

7. Loss of Independent Existence

The insured person is physically incapable of performing at least three (3) of the "Activities of Daily Living" as defined below (either with or without the use of mechanical equipment, special devices or other aids or adaptations in use for disabled persons) for a continuous period of at least six (6) months, signifying a permanent and irreversible inability to perform the same. For the purpose of this definition, the word "permanent" shall mean beyond the hope of recovery with current medical knowledge and technology. The Diagnosis of Loss of Independent Existence must be confirmed by a Registered Doctor who is a specialist. Only Life Insured with Insurance Age between 18 and 74 on first diagnosis is eligible to receive a benefit under this illness. Activities of Daily Living:

1. 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;

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

3. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;

4. Mobility: the ability to move indoors from room to room on level surfaces;

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

6. Feeding: the ability to feed oneself once food has been prepared and made available.

8. Blindness

Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident. 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. The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure.

9. Multiple Sclerosis with Persisting Symptoms

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 Other causes of neurological damage such as SLE is excluded.

10. Alzheimer's Disease

Alzheimer's (presenile dementia) disease is a progressive degenerative disease of the brain, characterised by diffuse atrophy throughout the cerebral cortex with distinctive histopathological changes. It affects the brain, causing symptoms like memory loss, confusion, communication problems, and general impairment of mental function, which gradually worsens leading to changes in personality. Deterioration or loss of intellectual capacity, as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's disease, resulting in progressive significant reduction in mental and social functioning, requiring the continuous supervision of the Insured Person. The diagnosis must be supported by the clinical confirmation of a Neurologist and supported by Our appointed Medical Practitioner. The disease must result in a permanent inability to perform three or more Activities of daily living with Loss of Independent Living" or must require the need of supervision and permanent presence of care staff due to the disease. This must be medically documented for a period of at least 90 days The following conditions are however not covered: a. neurosis or neuropsychiatric symptoms without imaging evidence of Alzheimer's Disease b. alcohol related brain damage; and c. any other type of irreversible organic disorder/dementia not associated with Alzheimer's Disease 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.

11. Open Heart Replacement or Repair of Heart Valves:

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

12. Deafness

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

13. Apallic Syndrome:

Universal necrosis of the brain cortex, with the brain stem intact. Diagnosis must be definitely confirmed by a Registered Medical practitioner who is also a neurologist holding such an appointment at

an approved hospital. This condition must be documented for at least one (1) month. The definition of approved hospital will be as given below: A hospital means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and the said act Or complies with all minimum criteria as under: a) has qualified nursing staff under its employment round the clock; b) has at least 10 in-patient beds, in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places; c) has qualified medical practitioner (s) in charge round the clock; d) has a fully equipped operation theatre of its own where surgical procedures are carried out e) maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

14. Benign Brain Tumour:

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. 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. 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. Brain Surgery

The actual undergoing of surgery to the brain, under general anaesthesia, during which a Craniotomy is performed. Burr hole and brain surgery as a result of an accident is excluded. The procedure must be considered necessary by a qualified specialist and the benefit shall only be payable once corrective surgery has been carried out.

16. Coma of Specified Severity:

A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following: a) no response to external stimuli continuously for at least 96 hours; b) life support measures are necessary to sustain life; and c) permanent neurological deficit which must be assessed at least 30 days after the onset of the coma The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

17. Major Head Trauma

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

18. Permanent Paralysis of Limbs

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

19. **Major Burns**

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

20. Motor Neurone Disease with Permanent Symptoms

Motor neurone disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

21. Surgery of Aorta

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

22. Chronic Lung Disease:

End stage lung disease causing chronic respiratory failure, where all of the following criteria are met:

1. Permanent oxygen therapy is required;

2. A consistent forced expiratory volume (FEV1) test value of less than one (1) liter (during the first second of a forced exhalation);

3. Baseline arterial blood gas analysis showing arterial partial oxygen pressure at a level of fifty-five (55) mmHg or less; and

4. Dyspnea at rest.

The diagnosis must be confirmed by a respiratory physician.

23. Chronic Liver Disease:

End Stage liver failure as evidenced by all of the following: (a) Permanent jaundice; (b) Ascites; and (c) Hepatic encephalopathy. (d) Esophageal or Gastric Varices and Portal Hypertension Irrespective of the above, liver failure due or related to alcohol or drug abuse is excluded.

24. Parkinson's Disease

Unequivocal Diagnosis of Parkinson's Disease by a Registered Medical Practitioner who is a neurologist where the condition: (a) cannot be controlled with medication; (b) shows signs of progressive impairment; and (c) Activities of Daily Living assessment confirms the inability of the Insured to perform at least three (3) of the Activities of Daily Living as defined in the Policy, either with or without the use of mechanical equipment, special devices or other aids or adaptations in use for disabled persons. Drug-induced or toxic causes of Parkinson's disease are excluded.

25. Cardiomyopathy

An impaired function of the heart muscle, unequivocally diagnosed as Cardiomyopathy by a Registered Medical Practitioner who is a cardiologist, and which results in permanent physical impairment to the degree of New York Heart Association classification Class III or Class IV, or its equivalent, based on the following classification criteria: Class III - Marked functional limitation. Affected patients are comfortable at rest but performing activities involving less than ordinary exertion will lead to symptoms of congestive cardiac failure. Class IV - Inability to carry out any activity without discomfort. Symptoms of congestive cardiac failure are present even at rest. With any increase in physical activity, discomfort will be experienced. The Diagnosis of Cardiomyopathy has to be supported by echographic findings of compromised ventricular performance. Irrespective of the above, Cardiomyopathy directly related to alcohol or drug abuse is excluded.

26. Loss of Limbs

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.

27. Primary (Idiopathic) Pulmonary hypertension

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. The NYHA Classification of Cardiac Impairment are as follows:

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

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

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.

28. Loss of Speech

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, and Throat (ENT) specialist.

29. Systematic lupus Eryth. with Renal Involvement

Multi-system, autoimmune disorder characterized by the development of auto-antibodies, directed against various self-antigens. For purposes of the definition of "Critical Illness", SLE is restricted to only those forms of systemic lupus erythematosus, which involve the kidneys and are characterized as Class III, Class IV, Class V or Class VI lupus nephritis under the Abbreviated International Society of Nephrology/Renal Pathology Society (ISN/RPS) classification of lupus nephritis (2003) below based on renal biopsy. Other forms such as discoid lupus, and those forms with only hematological and joint involvement are specifically excluded. Abbreviated ISN/RPS classification of lupus nephritis (2003): Class I - Minimal mesangial lupus nephritis Class II - Mesangial proliferative lupus nephritis Class III - Focal lupus nephritis Class IV - Diffuse segmental (IV-S) or global (IV-G) lupus nephritis Class V - Membranous lupus nephritis Class VI - Advanced sclerosing lupus nephritis the final diagnosis must be confirmed by a certified doctor specialising in Rheumatology and Immunology.

30. Aplastic Anaemia

Irreversible persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least two (2) of the following: (a) Blood product transfusion; (b) Marrow stimulating agents; (c) Immunosuppressive agents; or (d) Bone marrow transplantation. The Diagnosis of aplastic anaemia must be confirmed by a bone marrow biopsy. Two out of the following three values should be present: - Absolute Neutrophil count of 500 per cubic millimetre or less; - Absolute Reticulocyte count of 20,000 per cubic millimetre or less; and - Platelet count of 20,000 per cubic millimetre or less.

31. Muscular Dystrophy

Diagnosis of muscular dystrophy by a Registered Medical Practitioner who is a neurologist based on three (3) out of four (4) of the following conditions: (a) Family history of other affected individuals; (b) Clinical presentation including absence of sensory disturbance, normal cerebro-spinal fluid and mild tendon reflex reduction; (c) Characteristic electromyogram; or (d) Clinical suspicion confirmed by muscle biopsy. The condition must result in the inability of the Member to perform (whether aided or unaided) at least three (3) of the six (6) 'Activities of Daily Living' as defined, for a continuous period of at least six (6) months.

32. Poliomyelitis

The occurrence of Poliomyelitis where the following conditions are met:

1. Poliovirus is identified as the cause and is proved by Stool Analysis,

2. Paralysis of the limb muscles or respiratory muscles must be present and persist for at least 3 months.

33. Medullary Cystic Disease

Medullary Cystic Disease where the following criteria are met:

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

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

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

VI. For Cancer Protect Benefit the following definitions apply (only if Cancer Protect Benefit is chosen by the Master Policyholder)

1. Carcinoma-in-Situ of any organ (except skin)

i. Carcinoma in situ (CIS) means the focal autonomous new growth of carcinomatous cells confined to the cells in which it originated and has not yet resulted in the invasion and/or destruction of surrounding tissues. 'Invasion' means an infiltration and/or active destruction of normal tissue beyond the basement membrane. ii. The diagnosis of the Carcinoma in situ must always be supported by a histopathological report. iii. Furthermore, the diagnosis of Carcinoma in situ must always be positively diagnosed upon the basis of a microscopic examination of the fixed tissue, supported by a biopsy result. Clinical diagnosis does not meet this standard. iv. In the case of the cervix uteri, Pap smear alone is not acceptable and should be accompanied with cone biopsy or colposcopy with the cervical biopsy report clearly indicating presence of CIS. v. Clinical diagnosis or Cervical Intraepithelial Neoplasia (CIN) classification which reports CIN I, and CIN II (where there is severe dysplasia without carcinoma in situ) does not meet the required definition and are specifically excluded. vi. All CIS of the skin are specifically excluded. vii. This coverage is available to the first occurrence of CIS of same organ. Multiple claims from same organ will not be admissible.

2. Early stage Cancers

Early Stage Cancer shall mean first ever diagnosis with the presence of one of the following malignant conditions: i. Any malignant tumor of the thyroid, positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue, which is histologically classified as T1N0M0 according to the TNM classification system, or another equivalent classification ii. Prostate tumor should be histologically described as TNM Classification T1a or T1b or T1c are of another equivalent classification. iii. Chronic lymphocytic leukaemia classified as RAI Stage I or II; iv. Basal cell and Squamous skin cancer that has spread to distant organs beyond the skin, v. Hodgkin's lymphoma Stage I by the Cotswold's classification staging system. vi. All tumors of the urinary bladder histologically classified as T1N0M0 (TNM Classification) i. The Diagnosis must be based on histopathological features and confirmed by a Pathologist. Pre-malignant lesions and conditions, unless listed above, are excluded.

3. Cancer of Specified Severity: As defined in Part D 4.V.1. above.

VII. **For Accelerated Critical Illness Benefit and Additional Critical Illness the following exclusions apply (only if CI Benefit or ACI Benefit is chosen by the Master Policyholder)** No CI or ACI benefit will be payable in respect of any listed condition arising directly or indirectly from, though, in consequence of or aggravated by any of the following: i. Pre-Existing Conditions or conditions connected to a Pre-Existing Condition will be excluded. Pre-existing Disease means any condition, ailment, injury or disease: a. that is/are diagnosed by a physician not more than 36 months prior to the Date of commencement of cover issued by the Company or b. For which medical advice or treatment was recommended by, or received from, a physician not more than 36 months prior to the date of commencement of the policy . ii. Existence of any Sexually Transmitted Disease (STD) and its related complications iii. Self-inflicted injury, suicide, insanity and deliberate participation of the Member in an illegal or criminal act with criminal intent. iv. Use of intoxicating drugs / alcohol / solvent, taking of drugs except under the direction of a qualified medical practitioner. v. War – whether declared or not, civil commotion, breach of law with criminal intent, invasion, hostilities (whether war is declared or not), rebellion, revolution, military or usurped power or wilful participation in acts of violence. vi. Aviation other than as a fare paying passenger or crew in a commercial licensed aircraft. vii. Taking part in any act of a criminal nature with criminal intent. viii. Treatment for injury or illness caused by avocations / activities such as hunting, mountaineering, steeple-chasing, professional sports, racing of any kind, scuba diving, aerial sports, activities such as hand-gliding, ballooning, deliberate

exposure to exceptional danger. ix. Radioactive contamination due to nuclear accident. x. Failure to seek or follow medical advice, the Member has delayed medical treatment in order to circumvent the waiting period or other conditions and restriction applying to this policy. xi. Any treatment of a donor for the replacement of an organ. xii. Any illness due to a congenital defect or disease which has manifested or was diagnosed before the Insured attains aged 17. VIII. **For Cancer Protect Benefit the following exclusions apply (only if Cancer Protect Benefit is chosen by the Master Policyholder)** No Cancer benefit will be payable in respect of any listed condition arising directly or indirectly from, though, in consequence of or aggravated by any of the following: i. Pre-Existing Diseases are not covered. Pre-Existing Disease means any Cancer condition (primary or metastatic); pre-cancerous condition or related condition(s) a. that is/are diagnosed by a physician not more than 36 months prior to the Date of commencement of cover issued by the Company or b. For which medical advice or treatment was recommended by, or received from, a physician not more than 36 months prior to the date of commencement of the policy ii. Any investigation or treatment for any Illness, disorder, complication or ailment arising out of or connected with the pre-existing Illness shall not be covered. iii. No benefits will be payable for any condition(s) which is a direct or indirect result of any pre-existing conditions unless Member has disclosed the same at the time of proposal and the Company has accepted the same. iv. Any covered event or its signs or symptoms having occurred within the waiting period. v. Existence of any Sexually transmitted diseases and its related complications. vi. Self-inflicted injuries, suicide, insanity, and deliberate participation of the Member in an illegal or criminal act vii. Use of intoxicating drugs / alcohol / solvent, taking of drugs except under the direction of a qualified medical practitioner. viii. Radioactive contamination due to nuclear accident. ix. Failure to seek or follow medical advice, the Member has delayed medical treatment in order to circumvent the waiting period or other conditions and restriction applying to this policy. x. Any illness due to a congenital defect or disease which has manifested or was diagnosed before the Insured attains aged 17 IX. **For WoEH Benefit the following exclusions apply (only if WoEH Benefit is chosen by the Master Policyholder)** No benefits shall be payable with respect to any period of hospital confinement/ ICU stay unless the entire confinement/ICU stay and all the hospital services rendered and performed there had been recommended by a physician and are in accordance with the diagnosis and treatment of the condition for which the hospitalisation was required. No benefit shall be payable under the policy if a claim or event suffered by the Member is directly or indirectly caused by or exacerbated as a result of any of the following : i. Pre-Existing Conditions or conditions connected to a Pre-Existing Condition. Pre-existing Disease means any condition, ailment, injury or disease: a. that is/are diagnosed by a physician not more than 36 months prior to the Date of commencement of cover issued by the Company or b. For which medical advice or treatment was recommended by, or received from, a physician not more than 36 months prior to the date of commencement of the policy . ii. Hospitalization/treatment within the waiting period except for hospitalization/treatment due to accidental injuries. iii. Routine Eye tests, refractive errors of eyes, refractive surgery, ear examination iv. Any treatment due to any external congenital conditions v. Any dental surgery, extraction of impacted tooth/teeth, orthodontics or orthographic surgery, or Temporo-Mandibular Joint Disorder except as necessitated by an accidental injury. vi. Treatment arising from or traceable to pregnancy which shall include childbirth, infertility, , miscarriage, abortion, sterilization and contraception including complications relating thereto / treatment to assist reproduction including IVF treatment vii. Hospitalisation primarily for investigatory purpose, diagnosis, X-ray examination, general physical or routine medical examination; preventive treatments or medicines, treatments/examinations specifically for weight management regardless whether the same is caused (directly or indirectly) by a medical condition, or any treatment or study related to sleep disorder or sleep apnoea syndrome. viii. Convalescence, general debility, custodial, sanitaria, rehabilitation centre, nature care clinics, or respite care; or long term nursing care. ix. Stem cell implantation or surgery, harvesting/storage/any other treatment using stem cells, or any type of hormone replacement therapy. x. Any form of plastic surgery except to the extent that such surgery is necessary for the treatment of cancer, burns or accidental injuries happened during the contract period ; Cosmetic or aesthetic treatments of any description, treatment or surgery for change of life/ gender xi. Treatment of xanthelasma, syringoma, acne and alopecia. xii. Circumcision unless necessary for treatment of a disease or necessitated due to an accident. xiii. Hospitalisation and treatment of any kind not actually performed, necessary or reasonable, or any kind of elective surgery or treatment which is not medically necessary xiv. Any treatment for any Sexually Transmitted Disease (STD) and its related complications ; treatment of any sexual problem including impotence (irrespective of the cause) and sex changes/ gender reassignments or erectile dysfunction. xv. Treatment for or arising from any injury that is intentionally self-inflicted, including attempted suicide. xvi. Hospitalisation due to use or abuse of any substance, drug (not prescribed by any registered Medical Practitioner) or alcohol or treatment for de-addiction / smoking cessation programs or taking of poison. xvii. War or hostilities (whether declared or not), civil commotion, invasion, rebellion, revolution, military or usurped power or nuclear weapons/materials , chemical /biological weapons or radiation of any kind or wilful participation in acts of violence or in illegal or criminal act. xviii. Failure to seek or follow medical advice, delayed medical treatment in order to circumvent the waiting period or other conditions and restriction applying to this policy. xix. Any treatment related to donor screening or treatment including surgery to remove organs of a donor for the replacement of an organ (where Member is donor). xx. Ayurvedic, Homeopathy, Unani, Yoga and naturopathy, Siddha, reflexology, acupuncture, bone-setting, herbalist treatment, hypnotism, Rolfing, massage therapy, aroma therapy or any other treatments other than Allopathy / western medicines. xxi. Any treatment received outside India xxii. The following diseases/surgeries & any complications arising out of them will not be covered during the first 2 years from policy issuance date. a. Deviated Nasal Septum/ Nasal & Paranasal Sinus Disorders b. Diseases of Tonsils / Adenoids c. Surgery of Thyroid Gland excluding Malignancy d. All types of Hernia e. Hydrocele /Varicocele / Spermatocele f. Piles / Fissure / Fistula-in-Ano / Rectal Prolapse g. Benign Prostatic Hypertrophy h. Menstrual Irregularities, Dysfunctional Uterine Bleeding i. Hysterectomy with or without Bilateral Salpingo-oophorectomy excluding Malignancy j. Uterine Fibroid k. Calculus Diseases l. Prolapsed Intervertebral Disc m. Retinopathy / Retinal Detachment n. Peripheral Vascular Disease due to Diabetes / Diabetic Foot o. Renal Failure due to Diabetes p. Osteoporosis / Pathological Fracture q. Cataract r. Joint Replacements except due to an accident (one Knee or one Hip Replacement in a Policy Year) s. Congenital Internal Disease or Anomalies or Disorder

5. Waiting Period

180 days Waiting Period for CI Benefit, ACI Benefit and Cancer Protect Benefit a) The benefit shall not apply or be payable in respect of any listed conditions for which the symptoms have occurred or for which care, treatment or advice was recommended by or received from a Physician, or which first manifested itself or was contracted during the first six months from the date of commencement of cover of member. In the event of occurrence of any of the scenarios mentioned above, the Company will refund the premiums for that benefit for the member and member's benefit cover will terminate with immediate effect. b) No waiting period applies where the condition manifests due to accident. **45 days Waiting Period for WoEH Benefit** a) The benefit shall not apply or be payable in respect of hospitalisation during the first 45 days from the date of commencement of cover of member. b) No waiting period applies where the condition manifests due to accident.

6. Rider

Riders may be added subject to the prior approval of the regulator.

PART-E

This section is not applicable to Your policy.

PART-F

General Conditions

1. Assignment of Benefit Assignment of Benefit under the Policy will be governed by Section 38 of the Insurance Act, 1938, as amended from time to time. Please refer to Annexure II for details on this section.

2. Nomination Nomination under the Policy will be governed by Section 39 of the Insurance Act, 1938, as amended from time to time. Please refer to Annexure III for details on this section.

3. Incontestability Incontestability will be as per Section 45 of the Insurance Act, 1938, as amended from time to time. Please refer to Annexure IV for details on this section.

4. Non-Disclosure & Fraud Non-disclosure and Fraud will be as per Section 45 of the Insurance Act, 1938, as amended from time to time. Please refer to Annexure IV for details on this section. The Policy is subject to the terms and conditions as mentioned in the Policy document and is governed by the Laws of India.

5. Discharge of liability A receipt duly signed by the Master Policyholder or any other person authorized by the Master Policyholder will be a valid and sufficient discharge for us. The encashment of the cheque or credit of the proceeds to the bank account of Master Policyholder or person directed by the Master Policyholder will be sufficient discharge for the company.

6. Claim payment procedure For ATPD Benefit, ACI Benefit and TI Benefit, the Insurer will make payment to the extent of outstanding loan amount in favour of the Master Policyholder and the residual benefit amount, if any, shall be paid to the Member. For all other benefits, the claim amount payable on the happening of the contingent event covered under this policy, shall be paid to the Master Policyholder in line with the IRDAI framework and to the extent of outstanding loan amount. The payment of benefits to the Master Policyholder to the extent of outstanding loan amount shall be done by the Company provided a valid assignment has been made by the Member in favor of the Master Policyholder. Any residual benefit shall be paid to the beneficiary. In the absence of a valid assignment, the claim payment will be made to the beneficiary. The following documents need to be submitted to raise a claim: a) Duly filled and signed Claimant Statement Form b)Recent photograph of the claimantc Original Certificate of Insurance d)Certificate from the Master Policyholder confirming the status of the loan, for which cover is taken, if applicable. e)Death certificate of member issued by the local authority in case of death claim. f) Signed copy of photo identity proof of the claimant g) Current Address proof of the claimant (Any one of the following: Aadhar Card, Valid Passport or Driver's License, Voters ID are considered as proofs). h)Copy of cancelled cheque / bank statement / passbook of the bank account of the claimant where payment needs to be transferred. i)In case of natural death/ death due to illness - cause of death and Medical records (i.e. Admission notes, Discharge / Death summary, test reports, etc.) if any is required. j)In case of accidental death - FIR, Panchnama, Inquest report, Post mortem report and Driving licence is required. Train/ Plane/Ship ticket and boarding confirmation may be additionally required for EAD Benefit. k)All medical reports, case histories, investigation reports, treatment papers, discharge summaries. In case of Terminal illness - Definition Fulfilment documents are required. Any other documents or information as may be required by the Company for processing of the claim depending on the cause of the claim. All claims payments will be made in Indian currency in accordance with the prevailing exchange control regulations and other relevant laws and regulations in India.

7. Recovery We reserve the right to recover the amount from the Master Policyholder or the Member or any other person, if it is found that the Benefits are erroneously paid due to the fault of the Master Policyholder. In case we are not in a position to recover such amounts from the Member or any other person, the Master Policyholder will be liable to pay the said amount to the Company within 15 days from the date of its demand. However, the Master Policyholder will not be liable or responsible for any wrong payments made by the Company without any fault on the part of the Master Policyholder.

8. Governing Law & Jurisdiction The policy is subject to the terms and conditions as mentioned in the policy document and is governed by the laws of India. Indian courts shall have exclusive jurisdiction over any and all differences or disputes arising in relation to this Policy.

9. Notices Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post, facsimile or e-mail to- **In case of the Master Policyholder:** As per the details specified by the Master Policyholder in the Proposal Form / Change of Address intimation submitted by them. **In case of the Company: Address:** Group Solutions Service Desk ICICI Prudential Life Insurance Company Limited, Unit No. 901A, 901B, 1001A & 1002B, Prism Towers, Mindspace, Link Road, Goregaon (West), Mumbai-400104. Maharashtra. Maharashtra. **E-mail:** grouplife@iciciprulife.com The Company's website must be checked for the updated contact details. It is very important that you immediately inform the company about any change in the address or the beneficiary particulars.

10. Legislative changes This policy, including the premiums and the benefits under the policy, will be subject to the taxes and other statutory levies as may be applicable from time to time. The Master Policyholder / Member will be required to pay Goods and Services Tax, as applicable, as per the prevailing laws, regulations and other financial enactments as may exist from time to time, wherever applicable. All benefits payable under the policy are subject to the tax laws and other financial enactments as they exist from time to time. All provisions stated in this Policy are subject to the current guidelines issued by the Regulator as on date. All future guidelines that may be issued by the Regulator from time to time may also be applicable to this Policy.

11. Electronic Transactions All transactions carried out through Internet, 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 will be valid and legally binding on the Master Policyholder / Member / Beneficiaries as well as the Company. This will be subject to the relevant guidelines and terms and conditions as may be made applicable by the Company. The Company reserves the sole right to terminate, stop or do away with all or any of the said facilities without any prior intimation to the Master Policyholder / Member / Beneficiaries.

12. Audit The Insurer shall have the right to audit or cause audit into the accuracy of the Credit account statements of the insured Members in respect of which claims were settled on the completion of every Financial Year.

13. Force Majeure In the event where Company's performance or any other obligations are prevented or hindered as a consequence of any act of God or state, strike, lock out, legislation or restriction by any government or any other statutory authority or any other circumstances that lie beyond Company's anticipation or control, the performance of this policy shall be wholly or partially suspended during the continuance of such force majeure. The Company shall resume its obligations towards the Policy as soon as the Force Majeure event ceases. The Company undertakes to keep the IRDAI informed and take prior approval before effecting any of these changes.

14. Age Admitted We have issued this Policy considering the date of birth of the Member as declared by You/the member in the Proposal form/Member Data/ Member Consent Form as applicable, to be true and correct. However, if at any point of time it is found that the age of the Member as declared in the Member Data/ Member Consent Form/ Proposal form as applicable is different from the actual Age of the Member, then the Company reserves the right to cancel the member policy

15. Issue of duplicate policy We shall issue a duplicate of Policy document, on receipt of a written request for the same from You along with the necessary documents as may be required by Us and at such charges as may be applicable from time to time. The current charges for issuance of duplicate policy is ₹ 200. Freelook option is not available on issue of duplicate Policy document.

PART-G

Policy Servicing and Grievance Handling Mechanism

1. Customer service

For any clarification or assistance, You may submit your query or request through 'write to us' section on our mobile app or website.

You may contact Our advisor or call Our customer service representative (between 10.00 a.m. to 7.00 p.m, Monday to Saturday; excluding national holidays) on the numbers mentioned in the policy document or on Our website: www.iciciprulife.com. For our NRI customers or any claim related assistance or enquiries, you can call us 24*7 on the numbers specified in the policy document or on Our website: www.iciciprulife.com except on national holidays. Additionally, you can touch base with us through chat and WhatsApp for a host of servicing enquiries or request submissions.

Alternatively, You may communicate with Us at any of our branches or the customer service desk whose details are mentioned in the policy document. For updated contact details, we request You to regularly check Our website.

i. Grievance Redressal Officer:

If You do not receive any resolution from Us or if You are not satisfied with Our resolution, You may submit your concern to the designated grievance redressal officer (GRO) at the 'grievance redressal' section on our website, or write to us at at gro@iciciprulife.com . Alternatively, you may send a letter at the communication address mentioned below
Address:

ICICI Prudential Life Insurance Company Limited,
Unit No. 901A, 901B, 1001A & 1002B, Prism Towers,
Mindspace, Link Road, Goregaon (West),
Mumbai- 400104.
Maharashtra.

ii. Grievance Redressal Committee:

If You do not receive any resolution or if You are not satisfied with the resolution provided by the GRO, You may escalate the matter to Our internal grievance redressal committee at the 'grievance redressal' section on our website or write a letter at the address mentioned below:

ICICI Prudential Life Insurance Company Limited,
Unit No. 901A, 901B, 1001A & 1002B, Prism Towers,
Mindspace, Link Road, Goregaon (West),
Mumbai- 400104.
Maharashtra.

iii. Policyholders' Protection and Grievance Redressal Department:

If you are not satisfied with the response or do not receive a response from us within two weeks, you may approach Policyholders' Protection and Grievance Redressal Department, the Grievance Cell of the Insurance Regulatory and Development Authority of India (IRDAI) on the following contact details:

IRDAI Grievance Call Centre (BIMA BHAROSA SHIKAYAT NIVARAN KENDRA)

155255 (or) 1800 4254 732

Email ID: complaints@irdai.gov.in

You can also register your complaint online at**bimabharosa.irdai.gov.in**

Address for communication for complaints by fax/paper:
Policyholders' Protection and Grievance Redressal Department – Grievance Redressal Cell
Insurance Regulatory and Development Authority of India
Survey No. 115/1, Financial District, Nanakramguda, Gachibowli,
Hyderabad, Telangana State – 500032

Insurance Ombudsman:

The Central Government has established an office of the Insurance Ombudsman for redressal of grievances with respect to life insurance policies. As per Insurance Ombudsman Rules, 2017 and Insurance Ombudsman (Amendment) Rules, 2021, the Ombudsman shall receive and consider complaints or alleging deficiency in performance required of an insurer (including its agents and intermediaries) or an insurance broker, on any of the following grounds:

a. delay in settlement of claims, beyond the time specified in the regulations, framed under the Insurance Regulatory and Development Authority of India Act, 1999;
b. any partial or total repudiation of claims by the life insurer, General insurer or the health insurer;
c. disputes over Premium paid or payable in terms of insurance policy;
d. misrepresentation of policy terms and conditions at any time in the Policy Document or policy contract;
e. legal construction of insurance policies in so far as the dispute relates to claim;
f. policy servicing related grievances against insurers and their agents and intermediaries;
g. issuance of life insurance policy, general insurance policy including health insurance policy which is not in conformity with the Proposal Form submitted by the proposer;
h. non-issuance of insurance policy after receipt of Premium in life insurance and general insurance including health insurance; and
i. any other matter arising from non-observance of or non-adherence to the provisions of any regulations made by the Authority with regard to protection of policyholders' interests or otherwise, or of any circular, guideline or instruction issued by the Authority, or of the terms and conditions of the policy contract, in so far as such matter relates to issues referred to in clauses (a) to (h).

Manner in which complaint to be made

1. Any person who has a grievance against an insurer or insurance broker, may himself or through his legal heirs, Nominee or Assignee, make a complaint in writing to the Insurance Ombudsman within whose territorial jurisdiction the branch or office of the insurer or the insurance broker, as the case may be complained against or the residential address or place of residence of the complainant is located.
2. The complaint shall be in writing, duly signed or made by way of electronic mail or online through the website of the Council for Insurance Ombudsmen by the complainant or through his legal heirs, Nominee or Assignee and shall state clearly the name and address of the complainant, the name of the branch or office of the insurer against whom the complaint is made, the facts giving rise to the complaint, supported by documents, the nature and extent of the loss caused to the complainant and the relief sought from the Insurance Ombudsman.
3. No complaint to the Insurance Ombudsman shall lie unless—
a) the complainant has made a representation in writing or through electronic mail or online through website of the insurer or insurance broker concerned or the insurer named in the complaint and—
i. either the insurer or insurance broker, as the case may be had rejected the complaint; or
ii. the complainant had not received any reply within a period of one month after the insurer or insurance broker, as the case may be received his representation; or
iii. the complainant is not satisfied with the reply given to him by the insurer or insurance broker, as the case may be;
b) The complaint is made within one year—
i. after the order of the insurer rejecting the representation is received; or
ii. after receipt of decision of the insurer or insurance broker, as the case may be which is not to the satisfaction of the complainant;
iii. after expiry of a period of one month from the date of sending the written representation to the insurer or insurance broker, as the case may be if the insurer or insurance broker, as the case may be named fails to furnish reply to the complainant.
4. The Ombudsman shall be empowered to condone the delay in such cases as he may consider necessary, after calling for objections of the insurer or insurance broker, as the case may be against the proposed condonation and after recording reasons for condoning the delay and in case the delay is condoned, the date of condonation of delay shall be deemed to be the date of filing of the complaint, for further proceedings under these rules.
5. No complaint before the Insurance Ombudsman shall be maintainable on the same subject matter on which proceedings are pending before or disposed of by any court or consumer forum or arbitrator.
6. The Council for Insurance Ombudsmen shall develop a complaints management system, which shall include an online platform developed for the purpose of online submission and tracking of the status of complaints made under rule 14
The Ombudsman shall not award compensation exceeding more than Rupees Fifty Lakhs (including relevant expenses, if any).
We have given below the details of the existing offices of the Insurance Ombudsman. We request You to regularly check our website at www.iciciprulife.com or the website of the IRDAI at www.irdai.gov.in for updated contact details.

1. 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 **Areas of Jurisdiction:** Gujarat , Dadra & Nagar Haveli, Daman and Diu

2. BENGALURU: Office of Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560078 Tel: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in **Areas of Jurisdiction:** Karnataka

3. BHOPAL: Office of the Insurance Ombudsman, 1 st floor, "Jeevan Shikha", 60-B, Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462011. Tel: 0755-2769201, 2769202 and 2769203 Email: bimalokpal.bhopal@cioins.co.in **Areas of Jurisdiction:** Madhya Pradesh & Chhattisgarh

4. BHUBANESHWAR: Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel: 0674-2596455/2596249/2596003 Email: bimalokpal.bhubaneswar@cioins.co.in **Areas of Jurisdiction:** Odisha

5. CHANDIGARH: Office of the Insurance Ombudsman, Jeevan Deep Building, SCO 20-27, Ground Floor, Sector-17-A, Chandigarh - 160017 Tel.: 0172 -2706468 Email: bimalokpal.chandigarh@cioins.co.in **Areas of Jurisdiction:** Punjab, Haryana(excluding Gurugram, Faridabad, Sonepat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.

6. CHENNAI: Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai – 600 018. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in **Areas of Jurisdiction:** Tamil Nadu, Tamil Nadu Puducherry Town and Karaikal (which are part of Puducherry).

7. DELHI: Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel 011 – 46013992/23213504/23232481 Email: bimalokpal.delhi@cioins.co.in **Areas of Jurisdiction:** Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.

8. KOCHI: Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash,LIC Building, Opp to Maharaja's College,M.G.Road, Kochi - 682 011. Tel.: 0484 – 2358759 Email: bimalokpal.ernakulam@cioins.co.in **Areas of Jurisdiction:** Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.

9. GUWAHATI: Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001 (Assam). Tel.: 0361 - 2632204 / 2602205 / 2631307 Email: bimalokpal.guwahati@cioins.co.in **Areas of Jurisdiction:** Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.

10. 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 // 23376991 / 23376599 / 23328709 / 23325325 Email: bimalokpal.hyderabad@cioins.co.in **Areas of Jurisdiction:** Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.

11. 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 **Areas of Jurisdiction:** Rajasthan

12. KOLKATA: Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor,4, C.R. Avenue, Kolkatta - 700 072 Tel.: 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.co.in **Areas of Jurisdiction:** West Bengal, Sikkim, Andaman & Nicobar Islands.

13. LUCKNOW: Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 3500613 Email: bimalokpal.lucknow@cioins.co.in **Areas of Jurisdiction:** 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.

14. MUMBAI: Office of the Insurance Ombudsman,3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/27/29/31/32/33 Email: bimalokpal.mumbai@cioins.co.in **Areas of Jurisdiction:** Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.

15. NOIDA: Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4 th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in **Areas of Jurisdiction:** State of Uttarakhand 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, Gautam buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.

16. PATNA: Office of the Insurance Ombudsman, 2 nd Floor, Lalit Bhawan, North Wing Bailey Road, Patna 800001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in **Areas of Jurisdiction:** Bihar,Jharkhand

17. 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.: 020-24471175 Email: bimalokpal.pune@cioins.co.in **Areas of Jurisdiction:** Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

Annexure I- Details on Benefit Options, Coverage Options

Category/ Loan Type	LT 1	LT 2	LT 3	LT 4
Category / Loan Name				
Coverage Option(s)				
Benefit Option(s) chosen (in addition to Death Benefit)				

Annexure II – Section 38 – Assignment and Transfer of Insurance Policies

Assignment or transfer of a policy should be in accordance with Section 38 of the Insurance Act, 1938 as amended from time to time. The extant provisions in this regard are as follows: 1. This policy may be transferred/assigned, wholly or in part, with or without consideration. 2. An Assignment may be effected in a policy by an endorsement upon the policy itself or by a separate instrument under notice to the Insurer. 3. The instrument of assignment should indicate the fact of transfer or assignment and the reasons for the assignment or transfer, antecedents of the assignee and terms on which assignment is made. 4. The assignment must be signed by the transferor or assignor or duly authorized agent and attested by at least one witness. 5. The transfer of assignment shall not be operative as against an insurer until a notice in writing of the transfer or assignment and either the said endorsement or instrument itself or copy there of certified to be correct by both transferor and transferee or their duly authorised agents have been delivered to the insurer. 6. Fee to be paid for assignment or transfer can be specified by the Authority through Regulations. 7. On receipt of notice with fee, the insurer should Grant a written acknowledgement of receipt of notice. Such notice shall be conclusive evidence against the insurer of duly receiving the notice. 8. If the insurer maintains one or more places of business, such notices shall be delivered only at the place where the policy is being serviced. 9. The insurer may accept or decline to act upon any transfer or assignment or endorsement, if it has sufficient reasons to believe that it is a. not bonafide or b. not in the interest of the policyholder or c. not in public interest or d. is for the purpose of trading of the insurance policy. 10. Before refusing to act upon endorsement, the Insurer should record the reasons in writing and communicate the same in writing to Policyholder within 30 days from the date of policyholder giving a notice of transfer or assignment. 11. In case of refusal to act upon the endorsement by the Insurer, any person aggrieved by the refusal may prefer a claim to IRDAI within 30 days of receipt of the refusal letter from the Insurer. 12. The priority of claims of persons interested in an insurance policy would depend on the date on which the notices of assignment or transfer is delivered to the insurer; where there are more than one instruments of transfer or assignment, the priority will depend on dates of delivery of such notices. Any dispute in this regard as to priority should be referred to Authority. 13. Every assignment or transfer shall be deemed to be absolute assignment or transfer and the assignee or transferee shall be deemed to be absolute assignee or transferee, except a. where assignment or transfer is subject to terms and conditions of transfer or assignment OR b. where the transfer or assignment is made upon condition that i. the proceeds under the policy shall become payable to policyholder or nominee(s) in the event of assignee or transferee dying before the insured OR ii. the

insured surviving the term of the policy Such conditional assignee will not be entitled to obtain a loan on policy or surrender the policy. This provision will prevail notwithstanding any law or custom having force of law which is contrary to the above position. 14. In other cases, the insurer shall, subject to terms and conditions of assignment, recognize the transferee or assignee named in the notice as the absolute transferee or assignee and such person a. shall be subject to all liabilities and equities to which the transferor or assignor was subject to at the date of transfer or assignment and b. may institute any proceedings in relation to the policy c. obtain loan under the policy or surrender the policy without obtaining the consent of the transferor or assignor or making him a party to the proceedings. Disclaimer: This is a simplified version of Section 38 of the Insurance Act, 1938 as amended from time to time. The policyholders are advised to refer to the Insurance Act, 1938, as amended from time to time for complete and accurate details.

Annexure III – Section 39 – Nomination by policyholder

Nomination of a life insurance Policy is as below in accordance with Section 39 of the Insurance Act, 1938, as amended from time to time. The extant provisions in this regard are as follows: 1. The policyholder of a life insurance on his own life may nominate a person or persons to whom money secured by the policy shall be paid in the event of his death. 2. Where the nominee is a minor, the policyholder may appoint any person to receive the money secured by the policy in the event of policyholder's death during the minority of the nominee. The manner of appointment to be laid down by the insurer. 3. Nomination can be made at any time before the maturity of the policy. 4. Nomination may be incorporated in the text of the policy itself or may be endorsed on the policy communicated to the insurer and can be registered by the insurer in the records relating to the policy. 5. Nomination can be cancelled or changed at any time before policy matures, by an endorsement or a further endorsement or a will as the case may be. 6. A notice in writing of Change or Cancellation of nomination must be delivered to the insurer for the insurer to be liable to such nominee. Otherwise, insurer will not be liable if a bonafide payment is made to the person named in the text of the policy or in the registered records of the insurer. 7. Fee to be paid to the insurer for registering change or cancellation of a nomination can be specified by the Authority through Regulations. 8. On receipt of notice with fee, the insurer should grant a written acknowledgement to the policyholder of having registered a nomination or cancellation or change thereof. 9. A transfer or assignment made in accordance with Section 38 shall automatically cancel the nomination except in case of assignment to the insurer or other transferee or assignee for purpose of loan or against security or its reassignment after repayment. In such case, the nomination will not get cancelled to the extent of insurer's or transferee's or assignee's interest in the policy. The nomination will get revived on repayment of the loan. 10. The right of any creditor to be paid out of the proceeds of any policy of life insurance shall not be affected by the nomination. 11. In case of nomination by policyholder whose life is insured, if the nominees die before the policyholder, the proceeds are payable to policyholder or his heirs or legal representatives or holder of succession certificate. 12. In case nominee(s) survive the person whose life is insured, the amount secured by the policy shall be paid to such survivor(s). 13. Where the policyholder whose life is insured nominates his a. parents or b. spouse or c. children or d. spouse and children e. or any of them the nominees are beneficially entitled to the amount payable by the insurer to the policyholder unless it is proved that policyholder could not have conferred such beneficial title on the nominee having regard to the nature of his title. 14. If nominee(s) die after the policyholder but before his share of the amount secured under the policy is paid, the share of the expired nominee(s) shall be payable to the heirs or legal representative of the nominee or holder of succession certificate of such nominee(s). 15. If policyholder dies after maturity but the proceeds and benefit of the policy has not been paid to him because of his death, his nominee(s) shall be entitled to the proceeds and benefit of the policy. 16. The provisions of Section 39 are not applicable to any life insurance policy to which Section 6 of Married Women's Property Act, 1874 applies or has at any time applied. Where nomination is intended to be made to spouse or children or spouse and children under Section 6 of MWP Act, it should be specifically mentioned on the policy. In such a case only, the provisions of Section 39 will not apply. Disclaimer: This is a simplified version of Section 39 of the Insurance Act, 1938, as amended from time to time. The policyholders are advised to refer to The Insurance Act, 1938, as amended from time to time for complete and accurate details.

Annexure IV – Section 45 – Policy shall not be called in question on the ground of
mis-statement after three years

Provisions regarding policy not being called into question in terms of Section 45 of the Insurance Act, 1938, as amended from time to time are as follows: 1. No Policy of Life Insurance shall be called in question on any ground whatsoever after expiry of 3 yrs from a) the date of issuance of policy or b) the date of commencement of risk or c) the date of rider to the policy whichever is later. 2. On the ground of fraud, a policy of Life Insurance may be called in question within 3 years from a) the date of issuance of policy or b) the date of commencement of risk or c) the date of rider to the policy whichever is later. For this, the insurer should communicate in writing to the insured or legal representative or nominee or assignees of insured, as applicable, mentioning the ground and materials on which such decision is based. 3. Fraud means any of the following acts committed by insured or by his agent, with the intent to deceive the insurer or to induce the insurer to issue a life insurance policy: a) The suggestion, as a fact of that which is not true and which the insured does not believe to be true; b) The active concealment of a fact by the insured having knowledge or belief of the fact; c) Any other act fitted to deceive; and d) Any such act or omission as the law specifically declares to be fraudulent. 4. Mere silence is not fraud unless, depending on circumstances of the case, it is the duty of the insured or his agent keeping silence to speak or silence is in itself equivalent to speak. 5. No Insurer shall repudiate a life insurance Policy on the ground of Fraud, if the Insured / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries. 6. Life insurance Policy can be called in question within 3 years on the ground that any statement of or suppression of a fact material to expectancy of life of the insured was incorrectly made in the proposal or other document basis which policy was issued or revived or rider issued. For this, the insurer should communicate in writing to the insured or legal representative or nominee or assignees of insured, as applicable, mentioning the ground and materials on which decision to repudiate the policy of life insurance is based. 7. In case repudiation is on ground of mis-statement and not on fraud, the premium collected on policy till the date of repudiation shall be paid to the insured or legal representative or nominee or assignees of insured, within a period of 90 days from the date of repudiation. 8. Fact shall not be considered material unless it has a direct bearing on the risk undertaken by the insurer. The onus is on insurer to show that if the insurer had been aware of the said fact, no life insurance policy would have been issued to the insured. 9. The insurer can call for proof of age at any time if he is entitled to do so and no policy shall be deemed to be called in question merely because the terms of the policy are adjusted on subsequent proof of age of Member. So, this Section will not be applicable for questioning age or adjustment based on proof of age submitted subsequently.