care HEALTH INSURANCE

BEST HEALTH INSURANCE COMPANY IN RURAL SECTOR | CLAIMS SERVICE LEADER OF THE YEAR

INDIA INSURANCE SUMMIT & AWARDS 2024

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Critical Illness & Personal Accident Cover

Know Your Policy Better

Policy Terms and Conditions

1. PREAMBLE:

The proposal and declaration given by the proposer and other documents if any shall form the basis of this Contract and is deemed to be incorporated herein. The two parties to this contract are the Policy Holder/Insured/Insured Persons (also referred as You) and Care Health insurance Ltd. (also referred as We/Us), and all the Provisions of Indian Contract Act, 1872, shall hold good in this regard. The references to the singular include references to the plural; references to the male include the female and references to any statutory enactment include subsequent changes to the same and vice versa. The sentence construction and wordings in the Policy documents should be taken in its true sense and should not be taken in a way so as to take advantage of the Company by filing a claim which deviates from the purpose of Insurance.

All the Policy documents are as per the format prescribed, guided & approved by the Indian Insurance Regulator, honorable "Insurance Regulatory and Development Authority of India" which is constituted as per IRDA Act, 1999. The Policy construction is driven by IRDA Regulations and Protection of Policy Holder's Interests, 2002.

2. Definitions

For the purposes of interpretation and understanding of the product the Company has defined, herein below some of the important words used in the product and for the remaining language and the words the Company believes to mean the normal meaning of the English language as explained in the standard language dictionaries. The words and expressions defined in the Insurance Act, IRDA Act, Regulations notified by the Authority and Circulars and Guidelines issued by the Authority shall carry the meanings explained therein. The judicial pronouncements of the highest courts in India will have the effect on the definitions and the language used in this product. The terms and conditions, coverage's and exclusions, benefits, various procedures and concepts which have been built in to the product also carry the specified meaning assigned to them in the said language.

The terms defined below have the meanings ascribed to them wherever they appear in this Policy and, where appropriate, references to the singular include references to the plural; references to the male include the female and references to any statutory enactment include subsequent changes to the same and vice versa.

2.1. Standard Definitions:

2.1.1. **Accident/Accidental** is a sudden, unforeseen and involuntary event caused by external, visible and violent means.

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

(a) Central or State Government AYUSH Hospital or

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

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

i. Having at least 5 in-patient beds;

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

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

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

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

i. Having qualified registered AYUSH Medical Practitioner(s) in charge;

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

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

2.1.4. **Condition Precedent** shall mean a Policy term or condition upon which the Insurer's liability under the Policy is conditional upon.

2.1.5. **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

i. Internal Congenital Anomaly

Congenital anomaly which is not in the visible and accessible parts of the body

ii. External Congenital Anomaly

Congenital anomaly which is in the visible and accessible parts of the body

2.1.6. **Day Care Centre** means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under—

(a) has qualified nursing staff under its employment;

(b) has qualified Medical Practitioner/s in-charge;

(c) has a fully equipped operation theatre of its own, where surgical procedures is carried out.

(d) maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

2.1.7. **Day Care Treatment** refers to medical treatment and/or a surgical procedure which is:

i. undertaken under general or local anesthesia in a Hospital/Day Care Center in less than 24 hours because of technological advancement, and

ii. Which would have otherwise required Hospitalization of more than 24 hours.

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

2.1.8. **Disclosure to Information Norm:** The Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

2.1.9. **Emergency Care (Emergency)** means management for an illness or injury which results i n symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured Person's health.

2.1.10. **Grace Period** means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases. Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.

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

i. has qualified nursing staff under its employment round the clock;

ii. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;

iii. has qualified Medical Practitioner(s) in charge round the clock;

iv. has a fully equipped operation theatre of its own where surgical procedures are carried out;

v. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

2.1.12. **Hospitalization** means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

2.1.13. **Illness** means a sickness or a disease or a pathological condition leading to the impairment of normal physiological function and requires medical treatment.

(a) Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery

(b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

(a) It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests;

(b) It needs ongoing or long-term control or relief of symptoms;

(c) It requires rehabilitation for the patient or for the patient to be specially trained to cope with it;

(d) It continues indefinitely;

(e) It recurs or is likely to recur.

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

2.1.15. Medical Advice means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow-up prescription.

2.1.16. Medical Expenses means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other Hospitals or doctors in the same locality would have charged for the same medical treatment.

2.1.17. Medical Practitioner (not applicable for Overseas Travel Insurance) 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.

2.1.18. Migration means facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer

2.1.19. Network Provider (not applicable for Overseas Travel Insurance) means the Hospitals enlisted by an Insurer, TPA or jointly by an Insurer and TPA to provide medical services to an Insured by a Cashless Facility.

2.1.20. Non-Network means any hospital, day care centre or other provider that is not part of the network.

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

2.1.22. OPD Treatment is one in which the Insured Person visits a clinic/Hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or In-patient.

2.1.23. Portability means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer

2.1.24. Pre-existing Disease means any condition, ailment, injury or disease:

i. That is/are diagnosed by a physician, not more than 36 months prior to the date of commencement of the policy issued by the insurer; or

ii. 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.

2.1.25. Reasonable and Customary Charges means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness/ Injury involved.

2.1.26. Renewal defines the terms on which the contract of insurance can be renewed on mutual consent with a provision of Grace Period for treating the renewal continuous for the purpose of all waiting periods.

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

2.1.28. Subrogation (Applicable to other than Health Policies and health sections of Travel and PA policies) means the right of the Insurer to assume the rights of the Insured Person to recover expenses paid out under the Policy that may be recovered from any other source.

2.1.29. Surgery/Surgical Procedure means manual and/or operative procedure(s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a Hospital or a Day Care Centre by a Medical Practitioner.

2.1.30. Unproven/Experimental Treatment means a treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

2.1.31. Break in policy means the period of gap that occurs at the end of the existing policy term/installment premium due date, when the premium due for

renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.

2.2. Specific Definitions:

2.2.1. **Age** means the completed age (in years) of the Insured Person as on his last birthday.

2.2.2. **Company** means Care Health Insurance Limited.

2.2.3. **Hazardous Activities** means any sport or activity, which is potentially dangerous to the Insured Person whether he is trained or not. Such sport/activity includes stunt activities of any kind, adventure racing, base jumping, biathlon, big game hunting, black water rafting, BMX stunt/ obstacle riding, bobsleighing/ using skeletons, bouldering, boxing, canyoning, caving/ pot holing, cave tubing, rock climbing/ trekking/ mountaineering, cycle racing, cyclo cross, drag racing, endurance testing, hand gliding, harness racing, hell skiing, high diving (above 5 meters), hunting, ice hockey, ice speedway, jousting, judo, karate, kendo, lugging, risky manual labor, marathon running, martial arts, micro – lighting, modern pentathlon, motor cycle racing, motor rallying, parachuting, paragliding/ parapenting, piloting aircraft, polo, power lifting, power boat racing, quad biking, river boarding, scuba diving, river bugging, rodeo, roller hockey, rugby, ski acrobatics, ski doo, ski jumping, ski racing, sky diving, small bore target shooting, speed trials/ time trials, triathlon, water ski jumping, weight lifting or wrestling of any type.

2.2.4. **Insured Person (Insured)** means a person whose name specifically appears under Insured in the Policy Schedule and with respect to whom the premium has been received by the Company.

2.2.5. **Nominee** means the person named in the Policy Schedule who is nominated to receive the benefits under this Policy in accordance with the terms of the Policy, if the Policyholder is deceased.

2.2.6. **Policy** means these Policy Terms & Conditions, Specific Policy Conditions, Add-on Benefits (if any), the Proposal Form, Policy Schedule and Annexures which form part of the policy contract and shall be read together.

2.2.7. **Policy Schedule** means the certificate attached to and forming part of this Policy.

2.2.8. **Policyholder** means the person named in the Policy Schedule as the Policyholder.

2.2.9. **Policy Period** means the period commencing from the Policy Period Start Date and ending on the Policy Period End Date as specified in the Policy Schedule.

2.2.10. **Policy Period End Date** means the date on which the Policy expires, as specified in the Policy Schedule.

2.2.11. **Policy Period Start Date** means the date on which the Policy commences, as specified in the Policy Schedule.

2.2.12. **Sum Insured** means the amount specified against each Insured Person in the Policy Schedule which represents the Company's maximum, total and cumulative liability for that Insured Person for any and all Claims incurred in respect of that Insured Person during the Policy Period.

3. Benefits

General Conditions applicable to all Benefits:

1. Any Benefit shall be available only if the same is specifically mentioned in the Policy Schedule.

2. Admissibility of a Claim under Benefit 1 or Benefit 2 is a pre-condition to the admission of a Claim for Benefit 3 and the event giving rise to the Claim under the Benefit 1 or Benefit 2 shall be within the Policy Period for the Claim for such Benefit to be accepted.

3. The maximum, total and cumulative liability of the Company for an Insured Person for any and all Claims incurred under this Policy during the Policy Period in relation to any Insured Person shall not exceed the Sum Insured for that Insured Person. All Claims shall be payable subject to the terms, conditions and exclusions of the Policy and subject to availability of the Sum Insured.

4. Benefit 1 and Benefit 2 are mutually exclusive.

3.1 BENEFIT 1 : CRITICAL ILLNESSES, MEDICAL EVENTS & SURGICAL PROCEDURES

(a) If, during the Policy Period, an Insured Person:

(i) is diagnosed to be suffering from a Critical Illness or a Critical Illness manifests in that Insured Person; or

(ii) undergoes any Covered Surgical Procedure; or

(iii) suffers from any of the Covered Medical Events,

the Company will pay the Sum Insured as specified in the Policy Schedule against this Benefit.

(b) In case any Claim is admissible under this Benefit, coverage under the Policy for that Insured Person shall immediately and automatically terminate. However, other Insured Persons (if any) under this Policy shall continue to be covered under this Benefit.

(c)For the purpose of this Benefit, Critical Illness means the following illnesses and diseases to the extent described below only:

(I)Cancer

(i) A malignant tumour characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy

(II) The term cancer includes leukemia, lymphoma and sarcoma.

(III) The following are excluded:

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

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

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

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

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

vi. Chronic lymphocytic leukaemia less than RAI stage 3

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

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

ix. All tumors in the presence of HIV infection.

(ii) End Stage Renal Failure

(i) 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 consultant physician.

(iii) Multiple Sclerosis

(i) The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

(A) Investigations including typical MRI findings, which unequivocally confirm the diagnosis to be multiple sclerosis;

(B) There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months

(ii) Other causes of neurological damage such as SLE and HIV are excluded.

(iv) Benign Brain Tumor

I. Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.

II. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist. I. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or ii. Undergone surgical resection or radiation therapy to treat the brain tumor.

III. The following conditions are excluded: Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord

(v) Parkinson's Disease

(I) The unequivocal diagnosis of progressive degenerative idiopathic Parkinson's Disease by a consultant neurologist.

(II) This diagnosis must be supported by all of the following conditions:

(A) The disease cannot be controlled with medication

(B) Signs of progressive impairment

(C) Inability of the Insured Person to perform (whether aided or unaided) at least 3 of the following 5 “Activities of Daily Living” for a continuous period of at least 6 months .

(III) Activities of Daily Living:

(A) Transfer: Getting in and out of bed without requiring external physical assistance.

(B) Mobility: The ability to move from one room to another without requiring any external physical assistance.

(C) Dressing: Putting on and taking of all necessary items of clothing without requiring any external physical assistance.

(D) Bathing/Washing: The ability to wash in the bath or shower (including getting in and out of the bath or shower) or wash by other means.

(E) Eating: All tasks of getting food into the body once it has been prepared.

(IV) Parkinson's disease secondary to drug and/or alcohol abuse is excluded.

(vi) Alzheimer's Disease

(I) Alzheimer's (presenile dementia) disease is a progressive degenerative disease of the brain characterised by diffuse atrophy throughout the cerebral cortex with distinctive histopathologic changes.

(II) 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. This diagnosis must be supported by the clinical confirmation of an appropriate consultant neurologist and supported by the Company's appointed doctor.

(III) Exclusions :

(A) Non organic diseases such as neurosis and psychiatric illnesses;

(B) Alcohol related brain damage;

(C) Any other type of irreversible organic disorder/dementia;

(vii) End Stage Liver Disease

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

(A) Permanent jaundice;

(B) Uncontrollable ascites;

(C) Hepatic encephalopathy;

Liver failure secondary to alcohol or drug abuse is excluded.

(viii) Motor Neurone Disorder

(i) 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.

(ix) End Stage Lung Disease

(i) End Stage Lung Disease causing Chronic respiratory failure as confirmed and evidenced by all of following:

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

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

iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less ($PaO_2 < 55mmHg$); and

iv. Dyspnea at rest.

(x) Bacterial Meningitis

(i) Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal cord resulting in significant, irreversible and permanent neurological deficit. The neurological deficit must persist for at least 6 weeks. This diagnosis must be confirmed by:

(A) The presence of bacterial infection in cerebrospinal fluid by lumbar puncture;

(B) A consultant neurologist.

(II) Bacterial Meningitis in the presence of HIV infection is excluded.

(xi) Aplastic Anaemia

(I) Chronic persistent bone marrow failure which results in Anaemia, Neutropenia and Thrombocytopenia requiring treatment with at least one of the following:

(A) Blood product transfusion;

(B) Marrow stimulating agents;

(C) Immunosuppressive agents; or

(D) Bone marrow transplantation

(II) The diagnosis must be confirmed by a hematologist using relevant laboratory investigations including Bone Marrow Biopsy. Two out of the following three values should be present:

(A) Absolute Neutrophil count of 500 per cubic millimetre or less;

(B) Absolute Reticulocyte count of 20,000 per cubic millimetre or less; and

(C) Platelet count of 20,000 per cubic millimetre or less.

(d) For the purpose of this Benefit, Covered Surgical Procedures means undergoing any of the following Surgical Procedures as more specifically described below only, for the first time during the lifetime of the Insured Person :

(i) Major Organ Transplant

(i) The actual undergoing of a transplant of:

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

(B) Human bone marrow using haematopoietic stem cells.

(II) The undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.

(III) The following are excluded:

(A) Other stem-cell transplants;

(B) Where only islets of langerhans are transplanted.

(ii) Heart Valve Replacement

(I) The actual undergoing of open-heart valve surgery to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valves. 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.

(II) Exclusions:

(A) Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty.

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

The following are excluded:

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

(e) For the purpose of this Benefit, Covered Medical Events means occurrence of any of the following Medical Events as more specifically described below only, for the first time during the lifetime of the Insured Person :

(I) Stroke

(I) Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intra-cranial 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.

(II) Evidence of permanent neurological deficit lasting for atleast 3 months has to be produced.

(III) The following are excluded:

(A) Transient ischemic attacks (TIA);

(B) Traumatic injury of the brain;

(C) Vascular disease affecting only the eye or optic nerve or vestibular functions.

(ii) Paralysis

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

(iii) Myocardial Infarction

(I) 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 this will 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.

(II) The following conditions are excluded:

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

(B) Other acute Coronary Syndromes;

(C) Any type of angina pectoris.

(iv) 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

(v) Coma

(I) A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

(A) No response to external stimuli continuously for at least 96 hours;

(B) Life support measures are necessary to sustain life;

(C) Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

(II) The condition has to be confirmed by a specialist Medical Practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

(vi) Blindness

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

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

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

3.2 BENEFIT 2 : PERSONAL ACCIDENT

(a) If the Insured Person suffers an Injury during the Policy Period solely and directly due to an Accident that occurs during the Policy Period, which directly results in:

(i) The Insured Person's death within 12 months of the occurrence of the Injury; or

(ii) The Insured Person's Permanent Total Disablement within 12 months of the occurrence of the Injury such that the Insured Person is unable to resume his normal occupation

or engage in similar gainful employment due to the Permanent Total Disability suffered,

the Company will pay the Sum Insured as specified in the Policy Schedule against this Benefit.

(b) In case any Claim is admissible under this Benefit, coverage under the Policy for that Insured Person shall immediately and automatically terminate. However, other Insured Person shall continue to be covered under this Policy.

(c) If the Company has admitted a Claim for Permanent Total Disablement, then the Company shall not be liable to make any payment under the Policy on the death of the Insured Person, if the Insured Person subsequently dies.

(d) For the purposes of this Benefit, Permanent Total Disablement means:

(i) the total and irrecoverable loss of sight of both eyes; or

(ii) the actual loss by Physical Separation of both hands or both feet or one entire hand and one entire foot; or

(iii) the total and irrecoverable loss of use of both hands or both feet or of one hand and one foot without Physical Separation

(e) For the purposes of this Benefit, Physical Separation means as regards the hand actual separation at or above the wrists, and as regards the foot actual separation at or above the ankle.

3.3 BENEFIT 3 : CHILD EDUCATION

(a) If a Claim for any event under Benefit 1 or Benefit 2 of the Policy has been admitted, then in addition to any amount payable under that Benefit, the Company will pay the amount specified in the Policy Schedule against this Benefit, for the education of the Insured Person's child, provided that:

i. The child is less than Age 24 at the time of occurrence of the event; and

ii. Valid documentation establishing the relationship between with the child and the Insured Person and the Age of the child is submitted.

3.4 BENEFIT 4 : SECOND OPINION

(a) If the Insured Person is diagnosed with any Critical Illness (as specified under Benefit 1 of the Policy Terms & Conditions) during the Policy Period, then at the Policyholder's / Insured Person's request, the Company shall arrange for a Second Opinion from a Medical Practitioner at its own cost.

(b) It is agreed and understood that the Second Opinion will be based only on the information and documentation provided to the Company which will be shared with the Medical Practitioner and is subject to the following:

i. This Benefit can be availed a maximum of one time by an Insured Person during the Policy Year for each Critical Illness.

ii. The Insured Person is free to choose whether or not to obtain the Second Opinion and, if obtained under this Benefit, then whether or not to act on it.

iii. This Benefit is for additional information purposes only and does not and should not be deemed to substitute the Insured Person's visit or consultation to an independent Medical Practitioner.

iv. The Company does not provide a Second Opinion or make any representation as to the adequacy or accuracy of the same, the Insured Person's or any other person's reliance on the same or the use to which the Second Opinion is put.

v. The Company does not assume any liability for and shall not be responsible for any actual or alleged errors, omissions or representations made by any Medical Practitioner or in any Second Opinion or for any consequences of actions taken or not taken in reliance thereon.

vi. The Policyholder or Insured Person shall indemnify the Company and hold the Company harmless for any loss or damage caused by or arising out of or in relation to any opinion, advise, prescription, actual or alleged errors, omissions or representations made by the Medical Practitioner or for any consequences of any action taken or not taken in reliance thereon.

vii. Any Second Opinion provided under this Benefit shall not be valid for any medico-legal purposes.

viii. The Second Opinion does not entitle the Insured Person to any consultation from or further opinions from that Medical Practitioner.

(c) For the purposes of this Benefit only:

i. Second Opinion means an additional medical opinion obtained by the Company from a Medical Practitioner solely on the Policyholder or Insured

Person's express request in relation to a Critical Illness which the Insured Person has been diagnosed with during the Policy Period.

(d) Any Claim under this Benefit can be made only at the Company's Network Hospitals.

3.5 BENEFIT 5 : HEALTH CHECK-UP

a. On the Insured Person's request, the Company shall arrange for the Insured Person's Health Check-up in accordance with the table below at its Network Provider or any other Service Providers empanelled with the Company to provide the services, in India, provided that:

b. This Benefit shall only be available once during the Policy Year.

Age/Sum Insured	Up to 10 Lac	10 Lac-50 Lac	Above 50 Lac
Up to 45 years	Set 1	Set 2	Set 3
46 years to 55 years	Set 2	Set 3	Set 4
56 years & above	Set 3	Set 4	Set 5

Set	List of Medical Tests
Set 1	Complete Blood Count, Urine Routine, Blood Group, ESR, Fasting Blood Glucose, S Cholesterol, SGPT, Creatinine
Set 2	Complete Blood Count, Urine Routine, Blood Group, ESR, Hb1Ac, ECG, S Cholesterol, SGPT, Creatinine
Set 3	Complete Blood Count, Urine Routine, Blood Group, ESR, Hb1Ac, ECG, Lipid Profile, Kidney Function Test, Complete Physical Examination by Physician
Set 4	Complete Blood Count, Urine Routine, Blood Group, ESR, Hb1Ac, Lipid Profile, Stress Test (TMT) or 2D echo, Kidney Function Test, Liver Function Test, Complete Physical Examination by Physician
Set 5	Complete Blood Count, Urine Routine, Blood Group, ESR, Hb1Ac, Lipid Profile, Stress Test (TMT) or 2 echo, Kidney Function Test, Liver Function Test, Pulmonary Function Test, Complete Physical Examination by Physician

c. It is agreed and understood that details in the table above, including the list of medical tests is subject to review by the Company. The Company may revise or modify the above with prior approval from IRDA. In case these details are modified, the Policyholder shall be duly intimated at least three months prior to the date of Renewal when such modification comes into effect.

d. Any Claim under this Benefit can be made only at the Company's Network Provider or other Service Providers empanelled with the Company to provide the services.

4. Exclusions

1.1. Standard Exclusions:

(a) Permanent Exclusions applicable to Benefit 1 :

Any Claim in respect of any Insured Person for, arising out of or directly or indirectly due to any of the following shall not be admissible unless expressly stated to the contrary elsewhere in the Policy terms and conditions:

(a) Sterility and Infertility: (Code- Excl17)

Expenses related to sterility and infertility. This includes:

I. Any type of contraception, sterilization

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

III. Gestational Surrogacy

IV. Reversal of sterilization

(b) Permanent Exclusions applicable to all Benefits

Any Claim in respect of any Insured Person for, arising out of or directly or indirectly due to any of the following shall not be admissible unless expressly stated to the contrary elsewhere in the Policy terms and conditions:

(a) Breach of law: (Code- Excl10)

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

(b) Maternity: (Code Excl18)

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

ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

4.2. Specific Exclusions:

(a) Waiting Periods:

90-Day waiting period

(i) The Company shall not be liable to make any payment under Benefit 1 in respect of any Critical Illness, Medical Event or Surgical Procedure whose signs or symptoms first occur within 90 days of the Policy Period Start Date.

(ii) This exclusion shall not apply for subsequent Policy Periods provided that there is no break in insurance cover for that Insured Person and that the Policy has been renewed with the Company for

that Insured Person on time and for the same or lower Sum Insured.

(b) Permanent Exclusions:

1. Permanent Exclusions applicable to Benefit 1

Any Claim in respect of any Insured Person for, arising out of or directly or indirectly due to any of the following shall not be admissible unless expressly stated to the contrary elsewhere in the Policy terms and conditions:

(a) Any Claim with respect to any Critical Illness diagnosed or which manifested prior to Policy Period Start Date.

(b) Any external congenital illness or condition

(c) Any medical procedure or treatment, which is not medically necessary or not performed by a Medical Practitioner.

(d) Any physical, medical condition or treatment or service that is specifically excluded under the Special Conditions in the Policy Schedule.

(e) Any treatment relating to birth defects.

(f) Hormone replacement therapy.

(g) Any treatment through self-medication or any treatment that is not scientifically recognized.

2. Permanent Exclusions applicable to Benefit 2

Any Claim in respect of any Insured Person for, arising out of or directly or indirectly due to any of the following shall not be admissible unless expressly stated to the contrary elsewhere in the Policy terms and conditions:

(a) Payment of compensation in respect of death, Injury or disablement of Insured Person directly or indirectly caused by venereal disease or insanity except where such condition arises directly as a consequence of an Accident during the Policy Period.

3. Permanent Exclusions applicable to all Benefits

Any Claim in respect of any Insured Person for, arising out of or directly or indirectly due to any of the following shall not be admissible unless expressly stated to the contrary elsewhere in the Policy terms and conditions:

(a) Any condition caused by or associated with any sexually transmitted disease except arising out of HIV and not specifically mentioned in benefits above.

(b) Any Pre-existing Disease or any complication arising therefrom.

(c) Treatment of mental retardation, arrested or incomplete development of mind of a person, subnormal intelligence or mental intellectual disability.

(d) Acts of self-destruction or self-inflicted Injury, attempted suicide or suicide while sane or insane or any Illness or Injury attributable to consumption, use, misuse or abuse of tobacco, intoxicating drugs and alcohol or hallucinogens.

(e) Participation in any flying activity except as a bonafide fare-paying passenger in an aircraft that is authorized by the relevant regulations to carry such passengers between established aerodromes.

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

(g) Participation in actual or attempted felony, riots, civil commotion, criminal misdemeanor;

(h) Engaging in sporting activities in so far as they involve the training for or participation in competitions of professional sports.

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

(i) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

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

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

(j) Any Illness or Injury attributable to consumption, use, misuse or abuse of tobacco, intoxicating drugs, alcohol, hallucinogens, smoking.

5. GENERAL TERMS AND CLAUSES

5.1. Standard General Terms & Clauses

5.1.1. Disclosure of Information

The Policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact by the policyholder.

Note:

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

b. In continuation to the above clause the Company may also adjust the scope of cover and / or the premium paid or payable, accordingly.

5.1.2. Condition Precedent to Admission of Liability

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

5.1.3. Claim Settlement (provision for Penal Interest)

i. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of intimation on receipt of last necessary document.

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

iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest in any case not later than 15 days from the date of intimation on receipt of last necessary document. In such cases, the Company shall settle the claim within 45 days from the date of intimation on receipt of last necessary document.

iv. In case of delay beyond stipulated 45 days the company shall be liable to pay interest at a rate 2% above the bank rate from the date of intimation to the date of payment of claim.

Bank rate shall mean the rate fixed by the Reserve Bank of lndia (RBl) at the beginning of the financial year in which claim has fallen due

5.1.4. Complete discharge

Any payment to the policyholder, Insured Person or his/ her nominees or his/ her legal representative or Assignee or to the Hospital, as the case may be, for any benefit under the Policy shall be valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

5.1.5. FRUAD

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s) / policyholder(s) who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance Policy:-

A. The suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;

B. The active concealment of a fact by the Insured Person having knowledge or belief of the fact;

C. Any other act fitted to deceive; and

D. Any such act or omission as the law specially declares to be fraudulent

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

5.1.6. Cancellation / Termination

(a) The policyholder may cancel this policy by giving 7days'written notice and in such an event, the Company shall refund proportionate premium for the unexpired policy period.

(b) Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the Insured person under the Policy.

(c) If the risk under the Policy has already commenced, or only a part of the insurance\ coverage has commenced, and the option of\ Policy cancellation is exercised by the Policyholder, then the expenses such as pre-policy medical examination etc. incurred by the Company will also be deducted before refunding of premium.

(d) The Company may cancel the Policy at any time on grounds of mis-representations, non disclosure of material facts, fraud by the Insured Person, by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of mis-representations, non-disclosure of material facts or fraud.

Notes:

(a) In case of demise of the Policyholder,

(i) Where the Policy covers only the Policyholder, this Policy shall stand null and void from the date and time of demise of the Policyholder and the Company shall refund proportionate premium for unexpired Policy Period. Subject to no claim has been admitted or has been lodged or any benefit has been availed by the Insured person under the Policy.

(ii) Where the Policy covers other Insured Persons, this Policy shall continue till the end of Policy Period for the other Insured Persons. If the other Insured Persons wish to continue with the same Policy, the Company will renew the Policy subject to the appointment of a policyholder provided that:

I. Written notice in this regard is given to the Company before the Policy Period End Date; and

II. A person of Age 18 years or above, who satisfies the Company's criteria applies to become the Policyholder.

(b) The Company's liability in respect of an Insured Person shall cease upon making any refund of premium under this Policy in accordance with the terms and conditions hereof in respect of such an Insured Person and the benefit in respect of that Insured Person shall forthwith terminate.

5.1.7. Migration:

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy atleast 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits as per IRDAI guidelines on migration.

For Detailed Guidelines on Migration, kindly refer the link:

https://www.careinsurance.com/other-disclosures.html

5.1.8. Portability:

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits as per IRDAI guidelines on portability.

For Detailed Guidelines on Portability, kindly refer the link:

https://www.careinsurance.com/other-disclosures.html

5.1.9. Renewal of Policy

The policy shall ordinarily be renewable except on grounds of established fraud, or non-disclosure or misrepresentation by the insured person.

(a) Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.

(b) Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

(c) At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period

(d) No loading shall apply on renewals based on individual claims experience.

5.1.10. Withdrawal of Policy

I. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.

ii. Insured Person will have a one-time option to renew the existing product, if renewal falls within the 90 days from the date of withdrawal of the product or option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. as per IRDAI guidelines, provided the policy has been maintained without a break.

5.1.11. Moratorium Period

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

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

The Company may revise or modify the terms of the policy including the premium rates. The insured person shall be notified before the changes are affected.

5.1.13. Free Look Period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of 30 days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

a. A refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person (as per the below mentioned grid) and the stamp duty charges or

Pre-policy	Assure 2		Assure3 & Assure 4	
Age / Sum Insured	Up to 3 Crores	Above 3 Crores	Up to 10 Lac	Above 10 Lac
Up to 45 years	Nill	Rs. 1,000	Nil	Rs. 1,000
46 years to 55 years	Nill	Rs. 2,000	Rs. 1,000	Rs. 2,000
56 years and above	Rs. 1,000	Rs 4,500	Rs. 2,000	Rs. 4,500

b. Where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or

c. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

5.1.14. Grievances

In case of any grievance the insured person may contact the company through

Website: www.careinsurance.com

Toll free: 1800-xxx-xxxx

E-mail: customerfirst@careinsurance.com

Courier: Any of Company's Branch Office or corporate office

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.

If Insured person is not satisfied with the redressal of grievance through one of the above methods,

insured person may contact the grievance officer at Branch Office or corporate office.

For updated details of grievance officer, kindly refer the link

https://www.careinsurance.com/customer-grievance-redressal.html

If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.

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

Note: The Contact details of the Insurance Ombudsman offices have been provided as Annexure III.

5.1.15. Nomination:

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

5.2 Specific General Terms & Clauses

5.2.1. Material Change

It is a condition precedent to the Company's liability under the Policy that the Policyholder shall immediately notify the Company in writing of any material change in the risk on account of change in nature of occupation or business at his own expense, as per Annexure – II. The Company may adjust the scope of cover and / or the premium paid or payable, accordingly.

5.2.2. No constructive Notice

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

5.2.3. Policy Disputes

Any and all disputes or differences under or in relation to the validity, construction, interpretation and effect to this Policy shall be determined by the Indian Courts and in accordance with Indian law.

5.2.4. Limitation of Liability

Any Claim under this Policy for which the notification or intimation of Claim is received 12 calendar months after the event or occurrence giving rise to the Claim shall not be admissible, unless the Policyholder proves to the Company's satisfaction that the delay in reporting of the Claim was for reasons beyond his control.

5.2.5. Communication

(a) Any communication meant for the Company must be in writing and be delivered to its address shown in the Policy Schedule. Any communication meant for the Policyholder will be sent by the Company to his last known address or the address as shown in the Policy Schedule.

(b) All notifications and declarations for the Company must be in writing and sent to the address specified in the Policy Schedule. Agents are not authorized to receive notices and declarations on the Company's behalf.

Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

(c) Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

5.2.6. Alterations in the Policy

his Policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by the Company, which approval shall be evidenced by a written endorsement signed and stamped by the Company. However, change or alteration with respect to increase/ decrease of the Sum Insured shall be permissible only at the time of renewal of the Policy.

5.2.7. Out of all the details of the various Benefits provided in the Policy Terms and Conditions, only the details pertaining to Benefits chosen by

policyholder as per Policy Schedule shall be considered relevant

5.2.8. Electronic Transactions

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

5.2.9 Reasonable Care

Insured Persons shall take all reasonable steps to safeguard the interests against any Illness or Injury that may give rise to a Claim.

5.2.10. Records to be maintained

The Policyholder or Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Policyholder or Insured Person shall furnish such information as the Company may require under this Policy at any time during the Policy Period or Policy Year or until final adjustment (if any) and resolution of all Claims under this Policy.

6. OTHER TERMS AND CLAUSES

6.1. Claims Procedure and Management

6.1.1 Intimation

(a) If any event as covered under this Policy occurs, the Policyholder or Insured Person or Nominee as the case may be shall notify the Claim to the Company within thirty (30) days from the date of its occurrence either at the Company's call center or in writing.

(b) It is agreed and understood that the following details are to be provided to the Company at the time of intimation of Claim:

(i) Policy Number;

(ii) Name of the Policyholder;

(iii) Name of the Insured Person in respect of whom the Claim is made;

(iv) Nature of the event;

(v) Name and address of the attending Medical Practitioner and Hospital, if applicable;

(vi) Date of admission to Hospital, if applicable;

(vii) Any other information, documentation or details requested by the Company.

6.1.2. Documents to be submitted for registration of claim

The following information and documentation shall be submitted to the Company at the earliest and in any event within 30 days of occurrence of the event in respect of all Claimsand claim will be registered only on submission of below documents. The date of submission of such information shall be deemed as date of claim registration for the purpose of claim processing:

(a) General Claim documents

(i) Duly completed and signed claim form, in original.

(ii) Original discharge/ death summary from the Hospital;

(iii) Certificate from the attending Medical Practitioner of the Insured Person confirming, at least the following:

(I) Name of the Insured Person;

(II) Name, date of occurrence and medical details.

(iv) Any other information, documentation or details requested by the Company.

(b) Additional Claim documents for Benefit 1

(i) Certificate from the attending Medical Practitioner of the Insured Person confirming that the Claim does not relate to any Pre-Existing Illness or any Illness or Injury which was diagnosed or existed within the first ninety (90) days of the Policy Period Start Date.

(ii) Original investigation test reports,

indoor case papers and medical documents as specified under the respective Critical Illness, Covered Surgical Procedure or Covered Medical Event.

(c) Additional Claim documents for Benefit 2

Purpose of Document - Category	Indicative List of Documents
Identity Proof	Voter ID, Passport, PAN Card, Driving License, ration card, Aadhar, or any other proof accepted by the KYC norms as approved by the company and which is admissible in court of law.
Address Proof	Voter ID, Passport, Driving License
Age Proof	Voter ID, Passport, PAN Card, Matriculation Pass Certificate, Driving License, Birth Certificate
Incident Proof	FIR, Panchnama, Final Police Report, State Electricity Board Report, Factory Inspection Report, Forensic Report, Valid Passenger Ticket / Boarding Pass of the Common Carrier, or any other proof to the satisfaction of the Company.
Cause of Loss	Viscera Report, Post Mortem Report (if conducted), MLC report, Medical Report/Certificate stating the cause of death
Disability	Disability Certificate from Government Medical Board, Fitness Certificate, Medical Prescription
Death	Death Certificate
Claimant Identity	Succession Certificate, Identity Proof of Nominee, legal heirs or any other proof to the satisfaction of the company for the purpose of a valid discharge.
Medical Expenses	Hospital Discharge Summary, Bills, Receipts, Medical Practitioner Certificate, Medical/Clinical / Pathological/Diagnostics Records

Note:

I. The Company reserves the right to seek additional documents depending upon the cause of Claim or the Benefit /Add-on Benefit under which the Claim is made.

ii. Any one of the above documents under each category needs to be provided

(d) The Company shall condone delay on merit for delayed Claims where delay is proved to be for reasons beyond the control of the Policyholder or the Insured Person.

(e) Only in the event that original bills, receipts, prescriptions, reports or other documents have already been given to any other insurance company or to a reimbursement provider the Company will accept properly verified photocopies of such documents attested by such other insurance company/reimbursement provider along with an original certificate of the extent of payment received from such insurance company/reimbursement provider.

6.1.3 Policyholder's or Insured Person's duty at the time of Claim

It is agreed and understood that as a condition precedent for a Claim to be considered under this Policy:

(a) All reasonable steps and measures must be taken to avoid or minimize the quantum of any Claim that may be made under this Policy.

(b) Intimation of the Claim, notification of the Claim and submission or provision of all information and documentation shall be made promptly and in any event in accordance within timeframe specified in Clause 6 of the Policy Terms and Conditions.

(c) The Insured Person will, at the request of the Company, submit himself for a medical examination by the Company's nominated Medical Practitioner as often as the Company considers reasonable and necessary. The cost of such examination will be borne by the Company.

(d) The Company's Medical Practitioner and representatives shall be given access and co-operation to inspect the Insured Person's medical and Hospitalization records and to investigate the facts and examine the Insured Person.

(e) The Company shall be provided with complete documentation and information which the Company has requested to establish its liability for the Claim, its circumstances and its quantum.

6.1.4 Payment Terms

(a) All payments under this Policy shall be made in Indian Rupees and within India.

(b) The Company shall have no liability to make payment of a Claim under the Policy in respect of an Insured Person, once the Sum Insured for that Insured Person is exhausted.

(c) The Company shall not be liable for any Claims which are incurred from the due date of installment till the date and time of revival of the Policy.

(d) Additionally in the event of any Claim being lodged under the Policy for any cause whatsoever, all the subsequent premium installments shall immediately become due and payable notwithstanding anything to the contrary herein above contained. The Company shall have the right to recover and deduct any or all the pending installments from the Claim amount due under the Policy.

(e) Claim under Benefit 1 or Benefit 2 can be made only once during the Policy Period. The Claim shall be paid only for the Policy Period in which the event giving rise to Claim under Benefit 1 or Benefit 2 occurs.

Annexure 1 - List of Critical Illness

S.No.	Particulars	Plan Name		
		Assure 2	Assure 3	Assure 4
1	Cancer	Yes	Yes	Yes
2	End Stage Renal Failure	Yes	Yes	Yes
3	Multiple Sclerosis	Yes	Yes	Yes
4	Benign Brain Tumour	Yes	Yes	Yes
5	Total Blindness	Yes	Yes	Yes
6	Motor Neurone Disorder	Yes	Yes	Yes
7	End Stage Lung Disease	Yes	Yes	Yes
8	Major Organ Transplant	Yes	Yes	Yes
9	Heart Valve Replacement	Yes	Yes	Yes
10	Coronary Artery Bypass Graft	Yes	Yes	Yes
11	Stroke	Yes	Yes	Yes
12	Paralysis	Yes	Yes	Yes
13	Myocardial Infarction	Yes	Yes	Yes
14	Major Burns	Yes	Yes	Yes
15	Coma	Yes	Yes	Yes
16	Parkinson's Disease (Before the age of 50 years)	No	No	Yes
17	Alzheimer's Disease (Before the age of 50 years)	No	No	Yes
18	End Stage Liver Disease	No	No	Yes
19	Bacterial Meningitis	No	No	Yes
20	Aplastic Anaemia	No	No	Yes

Annexure II - Service Request Form - For Change in Occupation / Nature of Job
(Refer Clause 5.2.1 of Policy Terms and Conditions)

Please Note:

1) To be filled in by Policyholder in CAPITAL LETTERS only.
2) If there is insufficient space, please provide further details on a separate sheet. All attached documents form part of this service request.
3) This form has to be filled in and submitted to the company whenever the nature of job / occupation of any insured covered under the Policy changes subsequent to the issuance of the Policy.

Policyholder Details

Policy No. :

☐ Mr. ☐ Ms.

Name :

(First Name) (Last Name)

Details of the Insured Persons for whom details are to be updated

☐ Mr. ☐ Ms.

Name :

(First Name) (Last Name)

Occupation :

Declaration

I hereby declare, on my behalf and on behalf of all persons insured, that the above statement(s), answer(s) and / or particular(s) given by me are true and complete in all respects to the best of my knowledge and that I am authorized to provide / request for updation of the details on behalf of Insured Persons.

Date : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

Signature of the Policyholder : _____

Place :

(On behalf of all the persons insured under the Policy)

Note: The Company shall update its record with respect to the information provided above. Subsequently, the Company may review the risk involved and may alter the coverage and/or premium payable accordingly.

Annexure III - Office of the Ombudsman

OFFICE OF THE OMBUDSMAN	CONTACT DETAILS	JURISDICTION OF OFFICE (UNION TERRITORY, DISTRICT)
Ahmedabad	Insurance Ombudsman, Office of the Insurance Ombudsman, Jeevan Prakash, 6th floor, Tilak Marg, Near S.V College Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02 E-mail : bimalokpal.ahmedabad@cioins.co.in	Gujarat , Dadra & Nagar Haveli, Daman and Diu
Bengaluru	Office of the Insurance Ombudsman, Jeevan Soudha Building ,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka
Bhopal	Office of the Insurance Ombudsman, LIC of India Zonal Office Building, 1st Floor, South Wing, Jeevan Shikha, opp. Gayatri Mandir, 60-B, Hoshangabad Road, Bhopal-462011Tel.: 0755 - 2769201 / 2769202/ 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh & Chhattisgarh
Bhubaneshwar	Office of the Insurance Ombudsman, 62, Forest park, Bhubaneshwar – 751 009. Tel.: 0674 - 2596461 /2596455/ 2596429/ 2596003 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa
Chandigarh	Office of the Insurance Ombudsman, Jeevan Deep, Ground Floor, LIC of India Building, SCO 20-27, Sector 17-A, Chandigarh – 160 017. Tel.: 0172 – 2706468/ 2707468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab , Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh
Chennai	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry)
Delhi	Office of the Insurance Ombudsman, 2/2 A, 1st Floor, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481 / 23213504/ 46013992 Email: bimalokpal.delhi@cioins.co.in	Delhi, Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
Guwahati	Office of the Insurance Ombudsman, Jeevan Nivesh Building, 5th Floor, Nr. Panbazar, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 – 2632204/ 2632205 / 2631307 Email: bimalokpal.guwahati@cioins.co.in	Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
Hyderabad	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Hyundai Showroom, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122/ 23376599/ 23376991/ 23328709/ 23325325 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana and Yanam – a part of Territory of Pondicherry
Jaipur	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Ambedkar Circle Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@cioins.co.in	Rajasthan

Kochi	Office of the Insurance Ombudsman, 10TH Floor, LIC Building, Jeevan Prakash Opp. Maharaj College Ground M. G. Road, Ernakulam - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe – a part of Pondicherry
Kolkata	Office of the Insurance Ombudsman, 7th Floor of Hindusthan Bldg.(Annex), 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Andaman & Nicobar Islands, Sikkim
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	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
Mumbai	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz West, Mumbai - 400 054. Tel.: 022 –69038800/33 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
Patna	Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Baily Road, Patna Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand
Noida	Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120- 2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur
Pune	Office of the Insurance Ombudsman, Jeevan Darshan- LIC of India Bldg., 3rd Floor, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

The updated details of Insurance Ombudsman are available on website of IRDAI: www.irda.gov.in, on the website of General Insurance Council: www.gicouncil.org.in, on the Company's website www.carehealthinsurance.com or from any of the Company's offices. Address and contact number of Executive Council of Insurers –

Office of the 'Executive Council of Insurers'

3rd Floor, Jeevan Seva Annexe,

S.V. Road, Santacruz(W),

Mumbai – 400 054.

Tel : 022-69038800/33

Email- inscoun@cioins.co.in

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Registered Office: 5th Floor, 19 Chawla House, Nehru Place, New Delhi-110019
Correspondence Office: Vipul Tech Square, Tower C, 3rd Floor, Golf Course Road, Sector-43, Gurugram-122009 (Haryana)
CIN: U66000DL2007PLC161503 UIN:RHIHLIP21375V022021
IRDAI Registration Number - 148

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Care Health-
Customer App

WhatsApp
8860402452

Self Help Portal:
www.careinsurance.com/self-help-portal.html

Submit Your Queries/Requests:
www.careinsurance.com/contact-us.html

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