Part II of the Schedule

1. Definitions

For the purposes of this policy, the terms specified below shall have the meaning set forth:

"Accident" means an unexpected, unforeseen and undesirable event, especially one resulting in bodily injury.

"Bodily Injury" means any accidental physical bodily harm solely and directly caused by external, violent and visible and evident causes but does not include any sickness or disease.

"Company" means ICICI Lombard General Insurance Company Limited.

"Confirmation of Availability of Insurance" shall mean such confirmation, in such form, substance and manner specified by the Company, which is provided to the Insured and in which the Insured shall confirm that he/she is entitled to insurance coverage under this Policy, and further, in which the Company shall confirm the issuance of this Policy and the same shall be in accordance with the terms and conditions set forth on the website www.icicilombard.com

"Hospital" means any institution in India established for indoor care and treatment of sickness and injuries and which

(a) has been registered either as a Hospital or Nursing Home with the local authorities and is under the supervision of a registered and qualified Medical Practitioner; or

(b) should comply with minimum criteria as under:-

  i) it should have at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and in all other places 15 inpatient beds;

  ii) fully equipped operation theatre of its own, wherever surgical operations are carried out;

  iii) fully qualified nursing staff under its employment round the clock; and

  iv) fully qualified Medical Practitioner(s) should be in-charge round the clock; or

(c) by the nature of medical treatment is an institution which fulfils all such requirements as are necessary ordinarily or customarily for such medical treatment and shall be performed by a registered and qualified Medical Practitioner.

For the purpose of this definition, the term "Hospital" shall not include an establishment, which is a place of rest, a place for the aged, a place for drug-addicts or place of alcoholics, a hotel or any other like place.

"Hospitalisation" shall mean admission in any Hospital in India upon the written advice of a Medical Practitioner for a minimum period of 24 consecutive hours except in case of Specified Treatment, where the admission in such Hospital may be for a period of less than 24 hours.

For the purpose of this definition, the term "Specified Treatment" means any treatment or cure for any one or more of the following illnesses:

1. Cataract
2. Lithotripsy (Kidney stone removal)
3. Tonsillectomy
4. Dialysis
5. Dilatation &Curettage
6. Chemotherapy
7. Radiotherapy
8. TURP (Prostate Surgery)
9. Cardiac catheterization

"Illness" means sickness, disease first diagnosed during the period of insurance for which immediate treatment by a medical practitioner is necessary.

"Insured" means the Individual(s) whose name(s) are specifically appearing as such in Part I of the Schedule to this Policy.

"Limit of Indemnity" means the sum stated in the Schedule against the name of each Insured, which sum represents the Company's maximum liability for any and all claims for that Insured regardless of the number of claims made by that Insured or on his/her behalf during the Period of Insurance.

"Medical Practitioner" means a person who holds a degree/diploma of a recognised institute and is registered by Medical Council of respective States of India, if so required. The term Medical Practitioner would include Physician, Specialist, Anaesthetist and Surgeon.

"Medical Charges" means the necessary and reasonable charges incurred by the Insured for the medical treatment of the illness or Bodily Injury as an inpatient in a Hospital, and includes the costs of the stay in the Hospital, surgical treatment, treatment and care by medical staff, Medical Practitioner's fees, medicines and consumables including cost of pacemaker, cost of organs, artificial limbs etc as recommended by the Medical Practitioner.

"Period of Insurance" shall mean the period from Commencement of insurance cover to the End of the insurance cover and specifically appearing as such in Part I of the Schedule to this Policy.

"Policy" means the Policy booklet, the Schedule and any applicable endorsement. The Policy contains details of the extent of cover available to the Insured, the exclusions from the cover and the terms and conditions of the issue of the Policy.

"Post Hospitalisation" means relevant medical expenses incurred during a period up to 60 (sixty) days after hospitalization for an illness or bodily injury sustained and considered a part of a claim admissible under the policy.

"Pre-existing illness" Any condition, ailment or injury or related condition(s) for which the insured had signs or symptoms, and / or were diagnosed, and / or received medical advice/treatment, within 48 months prior to the first individual health policy with the company.

"Pre-hospitalisation" means relevant medical expenses incurred during a period up to 30 (thirty) days prior to hospitalization for an illness or bodily injury sustained and considered a part of a claim admissible under the policy.

"Sum Insured" means the maximum specified coverage, as mentioned in Part I of the Schedule to this Policy, that each Insured is entitled to in respect of benefit under this Policy.

2. Scope of the Cover

The Company will indemnify, subject always to the Limit of Indemnity, the Insured against:

(i) The Medical Charges incurred by the Insured, as a result of suffering Illness or Bodily Injury during the Period of Insurance, which on the advice of a Medical Practitioner requires Hospitalization;

(ii) Pre-hospitalization Medical Charges incurred by the Insured for a 30 day period immediately preceding the Insured's admission to the Hospital for the illness or Bodily injury;

(iii) Post-hospitalization Medical Charges incurred by the Insured for a 60-day period immediately succeeding the Insured's discharge from the Hospital for the illness or Bodily injury, Provided that the entire periods as specified in (ii) and (iii) above fall within the Period of Insurance.

Notwithstanding anything contained herein, this Policy shall not apply to any Medical charges incurred by the Insured in any place or geographical area other than in India. The Company's indemnification liability under this Policy shall not exceed Sum Insured per Insured Person as stated in the Part I of the Schedule during the Period of Insurance.

The following Charges shall be reimbursable under the Policy:

1. Room, Boarding Expenses as provided by the Hospital.
2. Nursing Expenses.
3. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees.
4. Anesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines and Drugs, Diagnostic Materials and X-ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, Artificial Limbs and Organs and similar expenses.

3. Exclusions

The Company shall not be liable or make any payment for any claim directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following:

3.1 Any pre-existing illness - The claims arising on account of or in connection with any Pre-existing illness shall be excluded from the scope of cover under the policy. This exclusion shall cease to apply, subject to the exclusions mentioned under sub-clause 3.4 herein below, if the Insured has taken a Healthcare Policy from the Company and has been covered under the Policy, without a break, for a period of 4 consecutive years immediately preceding the Period of Insurance. Notwithstanding the foregoing, Permanent Exclusions as mentioned under sub-clause 3.4 herein below shall not be covered under this Policy in any case.

3.2 Medical charges incurred within 30 days of inception date of the policy except those that are incurred as a result of bodily injury caused by an accident. This exclusion doesn't apply for subsequent renewals with the Company without a break.

3.3 Expenses incurred on treatment of following diseases within the first two years from the commencement of the Policy, will not be payable:

- Cataract
- Benign Prostatic Hypertrophy
- Myomectomy, Hysterectomy unless because of malignancy
- Hernia, Hydrocele
- Fistula in anus, piles
- Arthritis, gout, rheumatism
- Joint replacements unless due to accident
- Sinusitis and related disorders
- Stones in the urinary and biliary systems
- Dilatation and curettage
- Skin and all internal tumors/ cysts/nodules/ polyps of any kind including breast lumps unless malignant/adenoids and hemorrhoids
- Dialysis required for chronic renal failure
- Surgery on tonsils, adenoids and sinuses
- Gastric and Duodenal ulcers In case the above illnesses are not pre-existing at the commencement of this policy, then this exclusion shall cease to apply if the Insured has taken Healthcare Policy from the Company and has been covered under the policy, without a break, for a period of 2 consecutive years immediately preceding the Period of Insurance.

In case the above illnesses are pre-existing at the commencement of this policy, then this exclusion shall cease to apply if the Insured has taken a Healthcare Policy from the Company, without a break, for a period of 3 consecutive years immediately preceding the Period of Insurance.

3.4 Permanent Exclusions

i. Any Physical, Medical or mental condition or treatment or service which is specifically excluded in the Policy in Part I of the Schedule under Special Conditions.

ii. Routine medical, eye and ear examinations, cost of spectacles, laser surgery, contact lenses or hearing aids, vaccinations, issue of medical certificates and examinations as to suitability for employment or travel.

iii. Internal congenital illness

iv. Suicide or self-inflicted injury

v. Alcohol or Drug Abuse

vi. Illness or Injury whilst performing duties as a serving member of a military ora police force.

vii. Treatment relating to birth defects and external congenital illnesses.

viii. All dental treatment unless due to accident.

ix. Treatment traceable to Pregnancy and Childbirth, abortion and its consequences, tests and treatment relating to infertility and invitro fertilization. This will not apply to Ectopic Pregnancy proved by diagnostic means and is certified to be life threatening by the Medical Practitioner.

x. Birth control procedures and hormone replacement therapy.

xi. Prosthesis, corrective devices and medical appliances which are not required intra-operatively or for the illness for which the Insured was hospitalized.

xii. Treatment of mental illness, stress, psychiatric or psychological disorders, Aesthetic treatment, Cosmetic surgery and Plastic surgery unless necessitated due to accident or as a part of any illness.

xiii. Circumcision unless necessary for treatment of a diseases or necessitated due to an accident.

xiv. Vaccination and inoculation of any kind

xv. Any Sexually transmitted diseases. Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex syndrome (ARCS) and all diseases caused by and/ or related to the HIV.

xvi. The performance of hazardous sports of any kind.

xvii. Treatment by a family member and self-medication or any treatment that is not scientifically recognized.

xviii. Flying other than as a passenger on a scheduled regular carrier.

xix. Any criminal act.

xx. War invasion, act of foreign enemies, hostilities (whether declared or not), civil war, rebellion, revolution, insurrection, mutiny, military or usurped power, riot, strike, lockout, military or popular uprising, civil commotion martial law, loot, sack, pillage.

xxi. Any losses directly or indirectly due to contamination due to any act of terrorism, regardless of any contributory causes (if the insurer alleges that by reason of these exclusion any loss is not covered by this insurance, the burden of proving the contrary shall be upon the insured.

xxii. Nuclear weapons, materials ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel.

xxiii. Experimental and unproven treatment, diagnostic tests and treatment not consistent with or incidental to the diagnosis and treatment of any illness or injury for which hospitalization is required.

xxiv. Costs of donor screening or treatment including surgery to remove organs from a donor in case of transplant surgery.

xxv. Non-allopathic treatment.

xxvi. Treatment taken at home or received outside the country.

xxvii. Treatment taken from persons not registered as Medical Practitioners under respective medical councils.

xxviii. Vitamins and Tonics, Treatment of obesity, general debility, convalescence, run-down condition and rest cure.

xxix. Domiciliary Treatment

4. Policy Related Terms and Conditions

4.1 When & How to Claim - It is a condition precedent to the Company's liability that upon the discovery or happening of any Illness or Bodily Injury that may give rise to a claim under this Policy, the Insured or (if the Insured is incapacitated or a minor, then the Policy holder) shall undertake the following:

4.2 Claim Notification - The Policy holder or the Insured shall give immediate notice to ICICI Lombard Health Care (In house Service Provider) / Company by calling the toll free number as specified in the Health Card provided to the Insured under this Policy and also in writing at the address shown in the schedule with particulars as below:

Policy Number, name of the Insured Person availing treatment, Policy holder's relation to the insured, nature of illness/ injury, name and address of the attending Medical Practitioner/ Hospital and any other relevant information. This information needs to be provided to the Company immediately and prior to availing treatment and in any case within 7 days, failing which the ICICI Lombard Health Care (In house Service Provider) / Company has the right to treat the claim as inadmissible or to pay a maximum of 80% of the admissible amount, as they may deem fit in their sole discretion.

4.3 Prior Authorization - For Cashless hospitalization, the Insured must contact the ICICI Lombard Health Care (In house Service Provider) / Company at least 48 Hours before a planned hospitalization.

In an emergency situation the ICICI Lombard Health Care (In house Service Provider)/ Company should be contacted within 24 hours of hospitalization.

4.4 Claim processing - The ICICI Lombard Health Care (In house Service Provider) will process the claim and make all payments. The Policy holder or the insured is required to deliver to ICICI Lombard Health Care at their own expense, within 30 days of the Insured's discharge from Hospital (for post-hospitalization expenses, completion of post hospitalization period or completion of treatment which ever is earlier), any and all information and documentation concerning the claim or the Company's liability for it, including but not limited to:

- Duly filled claim form(s).
- Original bills, receipts and discharge certificate/card from the Hospital/Medical Practitioner. ICICI Lombard Health Care (In house Service Provider's)
- Original bills from chemists supported by proper prescription.
- Original Investigation test reports and payment receipts.
- Medical Practitioner's referral letter advising hospitalization in non-accident cases.
- Any other document as required by ICICI Lombard Health Care (In House Service Provider)

  If so requested by the Company, the Insured will have to submit to a medical examination by the Company's own Medical Practitioner as often as the Company considers necessary.

In the event of Insured's death, written notice accompanied by a copy of the post mortem report (if any) should be given to the Company within 14 days regardless of whether any notice has been given to the Company. In addition the Insurers shall have the right to require an autopsy in case of the death.

5. Cashless hospitalization Facility

The Company shall also provide Health Card to the Insured under this Policy to avail of Cashless hospitalization Facility. The Insured can avail of Cashless hospitalization facility under this Policy at the time of admission into any hospital which has a tie-up with ICICI Lombard Health Care (In House Service Provider) by production of this Card subject to the terms and conditions for the usage of the Card as communicated to the Insured by ICICI Lombard Health Care (In House Service Provider). Cashless facility will not be available if treatment is taken in a Hospital where the does not have any tie-up to provide such facility. However intimation to ICICI Lombard Health Care (In house Service Provider)/Company before or within 7 days of admission to the hospital is compulsory.

6. Payment of Claims

a. No indemnity is available for any period of less than 24 hours spent by the Insured in a hospital except in the case of Specified Treatment.

b. The Company's obligation to make payment for cataract surgery shall, subject always to the limit of indemnity, be Rs 20000/-for each eye.

PART III OF THE SCHEDULE

Standard Terms and Conditions

1. Incontestability and Duty of Disclosure
   The Policy shall be null and void and no benefit shall be payable in the event of untrue or incorrect statements, misrepresentation, mis-description or on non-disclosure in any material particular in the proposal form, personal statement, declaration and connected documents, or any material information having been withheld, or a claim being fraudulent or any fraudulent means or devices being used by the Insured or any one acting on his behalf to obtain any benefit under this Policy.
2. Reasonable Care
   The Insured shall take all reasonable steps to safeguard the interests of the Insured against accidental loss or damage that may give rise to the claim.
3. Observance of terms and conditions
   The due observance and fulfilment of the terms, conditions and endorsement of this Policy in so far as they relate to anything to be done or complied with by the Insured, shall be a condition precedent to any liability of the Company to make any payment under this Policy.
4. Material change
   The Insured shall immediately notify the Company by fax and in writing of any material change in the risk and cause at his own expense such additional precautions to be taken as circumstances may require to ensure safe operation of the Insured items or trade or business practices thereby containing the circumstances that may give rise to the claim and the Company may, adjust the scope of cover and / or premium, if necessary, accordingly.
5. Records to be maintained
   The Insured shall keep an accurate medical record containing all relevant particulars and shall allow the Company to inspect such record. The Insured shall within one month after the expiry of the Insurance Policy furnish such information as the Company may require.
6. No constructive Notice
   Any knowledge or information of any circumstances or condition in connection with the Insured in possession of any official of the Company shall not be the notice to or be held to bind or prejudicially affect the Company notwithstanding subsequent acceptance of any premium.
7. Notice of charge etc
   The Company shall not be bound to take notice or be affected by any notice of any trust, charge, lien, assignment or other dealing with or relating to this Policy, but the payment by the Company to the Insured or his legal representative of any compensation or benefit under the Policy shall in all cases be an effectual discharge to the Company.
8. Overriding effect of Part II of the Schedule
   The terms and conditions contained herein and in Part II of the Schedule shall be deemed to form part of the Policy and shall be read as if they are specifically incorporated herein; however in case of any inconsistency of any term and condition with the scope of cover contained in Part II of the Schedule, then the term(s) and condition(s) contained herein shall be read mutatis mutandis with the scope of cover/terms and conditions contained in Part II of the Schedule and shall be deemed to be modified accordingly or superseded in case of inconsistency being irreconcilable.
9. Duties of the Insured on occurrence of loss
   On the occurrence of any loss, within the scope of cover under the Policy the Insured shall:
   (i) Forthwith file/submit a Claim Form in accordance with 'Claim Procedure' Clause as provided in Part II of the Schedule.
   (ii) Assist and not hinder or prevent the Company or any of its agents in pursuance of their duties under 'Rights of the Company On Happening Of Loss' Clause as provided in this Part.

If the Insured does not comply with the provisions of this Clause or other obligations cast upon the Insured under this Policy, in terms of the other clauses referred to herein or in terms of the other clauses in any of the Policy documents, all benefits under the Policy shall be forfeited, at the option of the Company.

10. Subrogation
    In the event of payment under this Policy, the Company shall be subrogated to all the Insured's rights or recovery thereof against any person or organisation, and the Insured shall execute and deliver instruments and papers necessary to secure such rights.
    The Insured and any claimant under this Policy shall at the expense of the Company do and concur in doing and permit to be done, all such acts and things as may be necessary or required by the Company, before or after Insured's indemnification, in enforcing or endorsing any rights or remedies, or of obtaining relief or indemnity, to which the Company shall be or would become entitled or subrogated.
11. Contribution
    If at the time of the happening of any loss or damage covered by this Policy, there shall be existing any other insurance of any nature whatsoever covering the same, whether effected by the Insured or not, then the Company shall not be liable to pay or contribute more than its rateable proportion of any loss or damage.
12. Fraudulent claims
    If any claim is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the Insured or anyone acting on his behalf to obtain any benefit under this Policy, or if a claim is made and rejected and no court action or suit is commenced within twelve months after such rejection or, in case of arbitration taking place as provided therein, within twelve (12) calendar months after the Arbitrator or Arbitrators have made their award, all benefits under this Policy shall be forfeited.
13. Cancellation/ termination
    The Company may at any time, cancel this Policy, by giving 7 days notice in writing by Registered post/Acknowledgement Due post to the Insured at his last known address in which case the Company shall be liable to repay on demand a rateable proportion of the premium for the unexpired term from the date of the cancellation . The Insured may also give 7 days notice in writing to the Company, for the cancellation of this Policy, in which case the Company shall from the date of receipt of the notice cancel the Policy and retain the premium for the period this Policy has been in force at the Company's short period scales as mentioned herein below, provided that, no refund of premium shall be made if any claim has been made under the Policy by or on behalf of the Insured.

PERIOD ON RISK	RATE OF PREMIUM RETAINED
Up to 1 month	25% of annual rate
Up to 3 months	50% of annual rate
Up to 6 months	75% of annual rate
Exceeding six months	Full Annual Rate

14. Cause of Action/ Currency for payments
    No Claims shall be payable under this Policy unless the cause of action arises in India, unless otherwise specifically provided in Part II of the Schedule to this Policy. All claims shall be payable in India in Indian Rupees only.
15. Policy Disputes
    Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein is understood and agreed by both the Insured and the Company to be adjudicated or interpreted in accordance with the Laws of India and only competent Courts of India shall have the exclusive jurisdiction to try all or any matters arising hereunder. The matter shall be determined or adjudicated in accordance with the law and practice of such Court
16. Arbitration clause
    If any dispute or difference shall arise as to the quantum to be paid under this Policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties to the dispute/difference, or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators.
    Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.
    It is clearly agreed and understood that no difference or dispute shall

be referable to arbitration, as herein before provided, if the Company has disputed or not accepted liability under or in respect of this Policy. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this Policy that the award by such arbitrator/ arbitrators of the amount of the loss or damage shall be first obtained.

17. Renewal notice

a) The Company shall not be bound to give notice that the renewal premium is due. Every renewal premium (which shall be paid and accepted in respect of this Policy) shall be so paid and accepted upon the distinct understanding that no alteration has taken place in the facts contained in the proposal or declaration herein before mentioned and that nothing is known to the Insured that may result to enhance the risk of the company under the guarantee hereby given. No renewal receipt shall be valid unless it is on the printed form of the Company and signed by an authorised official of the Company. Any change in the risk needs to be intimated to the Company by the Insured.

b) Grace Period - The Policy may be renewed by mutual consent and in such event the renewal premium shall be paid to the Company on or before the date of expiry of the Policy and in no case later than 15 days (Grace Period) from the expiry of the Policy. Insured will be treated as continuously covered in terms of continuity of benefit during such Grace Period. However, the Company shall not be liable for any claim for the period for which the premium is not received by the Company.

c) Loading in case of Claims – The renewal premium shall be calculated as per the age of the senior most insured member as covered under the policy. A loading may be charged on the premium in case there is a claim in the expiring policy. The loading of premium is calculated as per the following scale:

i. In case of claim not pertaining to chronic Illness –

Claim Amount (Rs.)	Loading
0 - 25,000	Nil
25,001 - 50,000	10%
50,001 - 100,000	20%
100,001 – 200,000	50%
>200,000	75%

For subsequent renewals, there will be no loading unless there is a claim in any renewal policy.

ii. In case of claim pertaining to chronic illness like heart diseases, cancer, brain diseases, organ failure and cirrhosis of the liver, loading of 75% on the base premium will be applicable.The loading will be applicable for all subsequent renewals. If there are claims in the subsequent renewals , further loading of 75% would be applicable, subject to a maximum of 200% on the base premium.

The extent of loading thus derived would be applicable for all subsequent renewals.

For the purpose of determination of loading on renewal policies, chronic ailments mean any condition or Illness which is normally prolonged or recurrent, including but not limited to heart diseases, cancer, brain diseases, organ failure and cirrhosis of the liver.

18. Notices

Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post, or facsimile to In case of the Insured, at the last known address.
In case of the Company :
ICICI Lombard General Insurance Company Limited
ICICI Bank Towers
Bandra Kurla Complex
Mumbai 400 051
Notice and instructions will be deemed served 7 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

19. Customer Service

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

20. Grievances

In case the Insured is aggrieved in any way, the Insured may contact the Company at the specified address, during normal business hours. If the situation so arises that, no reply is received from the Company with in one month or the insured is not satisfied with the reply of the company, Insured may, subject to vested jurisdiction, approach Insurance Ombudsman for the redressal of his/ her grievance.

The detail of Insurance Ombudsman is available at IRDA website: www.irdaindia.org, from the website of General Insurance Council: www.generalinsurancecouncil.org.in or from the office of the Company.

Extensions/ Endorsements

Extension HC 01: Floater Benefit

Notwithstanding anything contrary contained in the Policy, the Company shall compensate the Insured for any and all claims made during the tenure of the policy by the Policy holder or the immediate family of the Policy holder. For the purpose of this extension the term "immediate family" shall include Policyholder's lawful spouse, dependent children, brother, sister and parents as specifically named in Schedule I.
The payment by the Company will be limited to the aggregate sum insured for the Policyholder and the immediate family of the Policyholder, for any and all claims made under the Policy.

Floater Benefit means the Sum Insured as specified for a particular Insured and the members of his/her family as covered under the policy, is available for any or all the members of his/her family for one or more claims during the tenure of the policy.

Extension HC 06 - Cumulative Bonus

The limit of indemnity shall be increased by 5% for each completed and continuous year of coverage under the Health Insurance policy with the Company or similar health insurance cover from any other Indian Insurance Company provided that no claim has been made by the Insured in the preceding year, but

i. The maximum cumulative Bonus shall not exceed 50% of the Limit of Indemnity under the Insured's first health insurance Policy issued by the Company.

ii. This clause does not alter the character of the insurance Policy or the right of the Company to decline or to renew or to cancel the policy or the terms upon which renewal is offered

iii. If a claim is made in any year where a cumulative increase has been applied, then the increased limit of indemnity applicable will be reduced by 10% of the Sum insured at next renewal.