TAX GAIN - Health Advantage Plus Policy

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, visible and evident causes but does not include any sickness or disease.

"Chronic Illness" means any illness that is long-lasting and / or permanent illness. Long-lasting in relation to the above shall mean any illness lasting for more than 3 months.

"Company" means ICICI Lombard General Insurance Company Limited.

"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; and

(b) complies 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;
- iv) fully qualified Medical Practitioner(s) should be in-charge round the clock; and
- v) maintains daily medical records of each of its patients; and

(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 such medical treatment 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 or recreation, 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 as an in-patient 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.

"Illness" means sickness, disease, ailment or unhealthy condition of mind or body.

"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 as Sum Insured in the Part I of the Schedule under Benefit 'A' and Benefit 'B' against the name of each Insured, which sum represents the Company's maximum liability, for the respective Benefit, 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, less the amount already claimed by the Insured from the Company under the respective Benefit under this Policy. However, the Limit of Indemnity will be reinstated to the extent any claim is rejected partly or wholly by the Company and there is no contingent or impending liability on the Company in respect of such claim.

"Medical Charges" means the necessary, reasonable and customary charges incurred by the Insured for the medical treatment of the Illness or Bodily Injury 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, artificial limbs, etc. or any expenses incurred on account of treatment by the Medical Practitioner.

"Medical Practitioner" means a person who holds a degree of a recognised institute and is registered or licensed by recognised Medical Council, if so required and acting within the scope of the license or registration granted to him/her. The term Medical Practitioner would include Physician, Specialist, Anaesthetist and Surgeon but would exclude the Insured and members of his/ her immediate family. Immediate family would comprise of Insured's spouse, children, brother(s), sister(s) and parent(s).

"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, any Extension and applicable endorsements under the Policy. The Policy contains details of the extent of cover available to the Insured, the exclusions under the cover and the terms and conditions of the issue of the Policy.

"Post-hospitalisation period" means the period upto 60 days after discharge of the Insured from the Hospital 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 period" means the period upto 30 days prior to Hospitalization of the Insured for an Illness or Bodily Injury sustained and considered a part of a claim admissible under the Policy.

"Recurrent illness" means an Illness which relapses repeatedly, with periods of remission in between.

"Specified Treatment" means any treatment or cure for any one or more of the following illnesses :

- Cataract
- Lithotripsy (Kidney stone removal)
- Tonsillectomy
- Eye Surgery
- Dialysis
- Dilatation & Curettage
- Chemotherapy
- Radiotherapy
- Coronary Angiography
- Cardiac catheterization

"Sum Insured" means the maximum liability of the Company under the Policy and stated in Part I of the Schedule.

2. BENEFIT A - BASIC HOSPITALIZATION COVER

2.1 SCOPE OF THE COVER

The Company will indemnify, subject always to the Limit of Indemnity under Benefit "A", the Insured against:

(i) The Medical Charges incurred by the Insured, as an in-patient in a Hospital where the Hospitalisation is for a minimum period of 24 consecutive hours, as a result of suffering Illness or Bodily Injury during the Period of Insurance, which on the written advice of a Medical Practitioner requires Hospitalization;

(ii) Medical Charges for Pre-hospitalization period incurred by the Insured;

(iii) Medical Charges for Post-hospitalization period incurred by the Insured. Provided that, Pre-hospitalization period, the period of Hospitalisation and the Post-hospitalization period, above fall within the Period of Insurance as stated in Part I of the Schedule.

Notwithstanding anything contained herein, this Benefit shall not apply to any Medical charges incurred by the Insured in any place or geographical area other than in India, unless otherwise agreed by the Company in writing by way of any Extension.

The following charges shall be reimbursable under Benefit A:

1. Room, Boarding and Nursing Expenses as charged by the Hospital where the Insured availed medical treatment.
2. Intensive Care Unit (ICU) charges.
3. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees.
4. Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Consumables, Medicines and Drugs, Diagnostic Materials and X-ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, Cost of Artificial Limbs.

2.2 EXCLUSIONS APPLICABLE TO BENEFIT

A 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:

(i) 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 Benefit A.

ii) Any Illness contracted 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.

iii) Expenses incurred on treatment of following diseases within the first 2 years from the commencement of the Policy, will not be payable :

- Cataract
- Benign Prostatic Hypertrophy
- Myomectomy, Endometriosis, Hysterectomy unless because of malignancy
- All types of Hernia, Hydrocele
- Fissures &/or Fistula in anus, haemorrhoids/piles
- Arthritis, gout, rheumatism and spinal disorders
- Joint replacements unless due to accident
- Sinusitis and related disorders
- Stones in the urinary and biliary systems
- Dilatation and curettage
- All types of Skin and internal tumours/ cysts/nodules/ polyps of any kind including breast lumps unless malignant
- Dialysis required for chronic renal failure
- Surgery on tonsils, adenoids and sinuses
- Gastric and Duodenal ulcers
- Deviated Nasal Septum

In case the above Illnesses are not Pre-existing illnesses at the commencement of this Policy, then this exclusion shall cease to apply if the Insured has taken the TAX GAIN - Health Advantage Plus Policy from the Company without a break, for a period of 2 consecutive years immediately preceding the Period of Insurance.

In case the above Illnesses are Pre-existing illnesses at the commencement of this Policy, then this exclusion shall cease to apply if the Insured has taken the TAX GAIN - Health Advantage Plus Policy from the Company, without a break, for 2 consecutive years immediately preceding the Period of Insurance. (applicable as per ext. HC - 27)

(iv) PERMANENT EXCLUSIONS

i) Any physical, medical or mental condition or treatment or service that 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 for correction of refractory errors, contact lenses or hearing aids, vaccinations, issue of medical certificates and examinations as to suitability for employment or travel or any other such purpose.

iii) Internal Congenital Condition.

iv) Suicide or self-inflicted injury.
v) Alcohol or drug abuse.
vi) Illness or Bodily Injury whilst performing duties as a serving member of a military or a police force.
vii) Treatment relating to birth defects and external Congenital Conditions.
viii) All dental treatment unless caused due to Accident.
ix) Treatment traceable to pregnancy and childbirth, abortion and its consequences, tests and treatment relating to infertility and invitro fertilization. However, the exclusion do 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, durable medical equipments and items and medical appliances/apparatus/machines, which are not required intra-operatively or for the Illness for which the Insured required Hospitalisation.
xii) Cost of cochlear implant(s).
xiii) Personal comfort and convenience items and services.
xiv) Charges for Nurses/Attendants, etc. incurred during Pre-hospitalisation period or Post-Hospitalisation period.
xv) Treatment of mental illness, stress, psychiatric or psychological disorders. Aesthetic treatment, cosmetic surgery and plastic surgery including any complications arising out of or attributable to these, unless necessitated due to Accident or as a part of any Illness.
xvi) Any treatment/surgery for change of sex or treatment/surgery / complications/ illness arising as a consequence thereof.
xvii) Circumcision unless necessary for treatment of a disease or necessitated due to an Accident.
xviii) Vaccination and inoculation of any kind.
xix) 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.
xx) The performance of hazardous sports of any kind.
xxi) Treatment by a family member and self-medication or any treatment that is not scientifically recognized.
xxii) Flying other than as a passenger on a scheduled regular carrier.
xxiii) Insured's involvement in any criminal act – whether intentional or otherwise.
xxiv) 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 or pillage.
xxv) Nuclear weapons, materials ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel.
xxvi) Experimental and unproven treatment, any Illness or Injury caused by or a result or consequence of undergoing of any experimental or unproven treatment, diagnostic tests and treatment not consistent with or incidental to the usual diagnosis and treatment of any Illness or Injury for which Hospitalization is required.
xxvii) Costs of donor screening or treatment including surgery to remove organs from a donor in case of transplant surgery.
xxviii) Non- allopathic treatment.
xxix) Treatment taken at home or received outside India.
xxx) Any travel or transportation expenses including ambulance charges.
xxxi) Treatment taken from persons not registered as Medical Practitioners under respective medical councils.
xxxii) Vitamins and tonics, treatment of obesity (including morbid obesity) and any other weight control programs, general debility, convalescence, run-down condition and rest cure.
xxxiii) Any treatment undertaken after the point at which it is certified by a Medical Practitioner that the condition is of such a nature that further medical treatment may serve to stabilize or maintain it but is unlikely to result in a material improvement within a reasonable time frame.
xxxiv) Domiciliary treatment.
xxxv) Any consequential or indirect loss or expenses arising out of or related to the Hospitalization.
xxxvi) Any treatment related to sleep disorder or sleep apnoea syndrome.
xxxvii) Any treatment charges or fees charged by any Medical Practitioner acting outside the scope of licence or registration granted to him by any medical council.
xxxviii) 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.

2.3 CASHLESS HOSPITALIZATION FACILITY APPLICABLE TO BENEFIT A

The ICICI Lombard Health Care(In house Service Provider) shall also provide a 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 the ICICI Lombard Health Care (In house Service Provider) by production of this health card subject to the terms and conditions for the usage of the health card as communicated to the Insured by the ICICI Lombard Health Care (In house Service Provider).

Cashless hospitalization facility will not be available if treatment is taken in a Hospital where the ICICI Lombard Health Care (In house Service Provider) does not have any tie-up to provide such facility. The ICICI Lombard Health Care (In house Service Provider) shall have the right to deny cashless hospitalization facility in case accurate and complete information is not forth coming for the Illness or Bodily Injury for which cashless hospitalization facility is sought. It shall be at the sole discretion of the ICICI Lombard Health Care (In house Service Provider) to provide this cashless hospitalization facility under the above mentioned circumstances if it so deems fit.

However, intimation to the ICICI Lombard Health Care (In house Service Provider) with accurate and complete details regarding Hospitalization before or within 7 days of admission to the Hospital is compulsory to avail of the cashless hospitalization facility.

3. TERMS AND CONDITIONS APPLICABLE TO BENEFIT A

3.1 WHEN AND HOW TO MAKE A 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 his representative) shall undertake the following:

3.1.1 CLAIM NOTIFICATION

The Insured or his representative, as the case may be, shall give immediate notice to the ICICI Lombard Health Care (In house Service Provider)/Company by calling the toll free number as specified in the health card/ Policy provided to the Insured and also in writing at the address of the Company with particulars as below:

- Policy Number;
- Name of the Insured availing treatment;
- Policyholder's relation to the Insured;
- Nature of Illness or Bodily Injury;
- Name and address of the attending Medical Practitioner and the Hospital; and
- Any other relevant information. The above information needs to be provided to the ICICI Lombard Health Care (In house Service Provider)/Company immediately and prior to availing treatment and in any case within 7 days from date of admission/date of availing treatment, 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 at their sole discretion.

3.1.2 PRIOR AUTHORIZATION

For cashless Hospitalization, the Insured must contact the ICICI Lombard Health Care (In house Service Provider) at least 48 hours before a planned Hospitalization. In an emergency situation the ICICI Lombard Health Care (In house Service Provider) should be contacted within 24 hours of Hospitalization.

3.1.3 CLAIM PROCESSING

The ICICI Lombard Health Care (In house Service Provider) will process the claim and make all payments.

The Policyholder or the Insured is required to deliver at their own costs, to the ICICI Lombard Health Care (In house Service Provider), within 30 days of the Insured's discharge from Hospital (and for Post-hospitalization medical charges, within 30 days from the completion of Post-hospitalization period or completion of treatment, whichever is earlier), any and all information and documentation in original concerning the claim or the Company's liability for it, including but not limited to :

- Duly completed claim form(s).
- Original bills, receipts and discharge certificate/card from the Hospital/Medical Practitioner.
- Original bills from chemists supported by proper prescription.
- Original investigation test reports and payment receipts.
- Indoor case papers
- Medical Practitioner's referral letter advising Hospitalization in non-Accident cases.
- Any other document as required by theICICI Lombard Health Care (In house Service Provider). If so requested by the ICICI Lombard Health Care (In house Service Provider), the Insured will have to submit to a medical examination by the Company nominated Medical Practitioner as and when 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 prior notice has been given to the Company. In addition, the Company shall have the right to require an autopsy in case of the death.

3.2 PAYMENT OF CLAIMS (APPLICABLE TO BENEFIT A):

3.2.1 Any relapse of the Illness or Bodily Injury covered under the Policy within 45 days of the date when the Insured was last treated by the Medical Practitioner shall be deemed to be the part of the same claim.
3.2.2 No indemnity under this Benefit A is available if the period of Hospitalization is less than 24 hours except in the case of Specified Treatment.
3.2.3 The Company's obligation to make payment for cataract surgery shall, subject always to the limit of indemnity, be Rs 20000/- for each eye.

4. BENEFIT B – OUTPATIENT TREATMENT COVER

4.1 SCOPE OF THE COVER

The Company hereby agrees subject to the terms, conditions and exclusions herein contained or otherwise expressed herein, that, if during the Period of Insurance stated in Part I of the Schedule, the Insured shall incur any medical charges related to medical treatment taken at a Hospital, the Company shall pay to the Insured, the amount of such Medical Charges as are reasonably and necessarily incurred thereof, by or on behalf of such Insured but not exceeding the aggregate Sum Insured under Benefit 'B' for a particular Insured as appearing in the Part I of the Schedule hereto.

4.2 THE FOLLOWING CHARGES SHALL BE REIMBURSABLE UNDER BENEFIT B:

1. Room, Boarding Expenses as charged by the Hospital.
2. Nursing Expenses.
3. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees.
4. Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Consumables, Medicines and Drugs, Diagnostic Materials and X-ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, Cost of Artificial Limbs External Medical Aids, Dental treatment charges, ambulance charges.

4.3 EXCLUSIONS APPLICABLE TO BENEFIT B :

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:

i) Suicide or self-inflicted injury
ii) Alcohol or drug abuse

iii) Treatment by a family member and self-medication or any treatment that is not scientifically recognized.
iv) Treatment received outside the country.
v) Non- allopathic treatment.
vi) Insured's involvement in any criminal act– whether intentional or otherwise.
vii) 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 or pillage.
viii) Nuclear weapons, materials ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel.
ix) Experimental and unproven treatment.
x) Any treatment charges or fees charged by any Medical Practitioner acting outside the scope of licence or registration granted to him by any medical council.
xi) Any losses directly or indirectly due to contamination caused by any act of terrorism, regardless of any contributory causes (if the Company alleges that by reason of these exclusion any loss is not covered by this Policy, the burden of proving the contrary shall be upon the Insured.)

5. BASIS OF ASSESSMENT OF CLAIMS APPLICABLE TO BENEFIT B :

The claim payable under Benefit B shall be such Medical Charges incurred by or on behalf of the Insured for medical treatment of the Insured for any Illness or Bodily Injury but not exceeding the Limit of Indemnity as specified under Benefit 'B' in respect of such Insured.

6. CLAIM PROCEDURE APPLICABLE TO BENEFIT B:

6.1 CLAIM DOCUMENTS:

The Insured shall be required to furnish the following documents in original for or in support of a claim:

- Duly completed claim form.
- Discharge Card (if applicable) or OPD card of the Hospital.
- Prescription of the treating Medical Practitioner, bills, receipts, etc.
- Bills from chemists supported by proper prescription.
- Test reports and payment receipts.
- Any other document as required by the ICICI Lombard Health Care (In house Service Provider).

6.2 PAYMENT OF CLAIMS:

Claims pertaining to each Insured can be lodged only once during the Period of Insurance. The Company shall not receive any claims prior to completion of 90 days of the commencement of the Policy. Claims under this Benefit B shall be payable only on re-imbursement basis. No claim shall be admissible under this Benefit B, 30 days after expiry of the Period of Insurance.

7. GENERAL CONDITIONS APPLICABLE TO THE POLICY

7.1 It is hereby declared and agreed that:

a) Any notice or declaration for the attention of any Insured shall be deemed served if sent by the Company to the Policyholder at his/her address given in the Schedule.

b) Any payment due to any Insured under this Policy shall be paid by the Company to the Policyholder and the receipt by the Policyholder shall be complete discharge of the Company's liability against the claim. The Company shall not be responsible for any liability arising out of the Policyholder's delay or default in making payment to any Insured . However, the Company reserves its right to pay the claim directly to the Insured in whose respect the claim has been lodged.

7.2 Payment of Claim under each Benefit :

The Insured can lodge a claim under this Policy for the same insured event either under Benefit A or Benefit B.

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 from taking any reasonable steps in pursuance of their duties for ascertaining the admissibility of the Claim under the Policy. 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 15 days notice in writing by Registered post/Acknowledgement Due post to the Policyholder at the address mentioned in the Schedule in which case the Company shall be liable to repay on demand to the Policyholder, a rateable proportion of the premium for the unexpired term from the date of the cancellation. The Policyholder may also give 15 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	100% of 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 or Extensions to this Policy. All claims shall be payable in India in Indian Rupees only.
15. Policy Disputes
It has been agreed between the parties that any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein is understood and agreed to be adjudicated or interpreted in accordance with Indian Laws and only competent Indian courts 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.

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 know address.
    In case of the Company:
    ICICI Lombard General Insurance Company Limited
    ICICI Bank Towers Bandra Kurla Complex, Mumbai 400 051
    AND
    ICICI Lombard General Insurance Company Limited
    Zenith House, Keshav Rao Khadye Marg,
    Mahalaxmi, Mumbai 400 034.

    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 AVAILABLE UNDER THE BENEFIT 'A':

Extension HC 01: Floater Benefit

Floater Benefit: means the aggregate Sum Insured under Benefit 'A', as specified for a particular Insured and the members of his/her Immediate Family, is available for any or all the members of his/her Immediate Family for one or more claims during the tenure of the Policy subject always to the Limit of Indemnity. The payment by the Company will be limited to the aggregate Sum Insured under Benefit 'A' for the Insured and member of his/her Immediate Family, for any and all claims made under Benefit 'A'.

For the purpose of this Extension the term "Immediate Family" shall include Policyholder's lawful spouse, dependent children and dependent parents whose name(s) are specifically appearing in Part I of the Schedule to this Policy.

Notwithstanding anything stated here in above, the Company shall compensate the Insured for any and all claims made by the Insured or on his behalf under the Floater Benefit, only when such a claim made by the Insured is admissible under Benefit "A"

Extension HC 06- Cumulative Bonus

The Limit of Indemnity under Benefit 'A' shall be increased by 5% for each completed and continuous Period of Insurance under the Policy with the Company or similar tax gain insurance cover from any other Indian insurance company, in which case the Insured should not have attained the age of 70 years as on the date of renewal of the Policy with the Company, provided that no claim has been made by the Insured in the preceding year. This Extension is subject to the following:

i) The maximum cumulative bonus shall not exceed 50% of the Sum Insured under Benefit 'A' under the Insured's first Policy issued by the Company.
ii) This clause does not alter or affect the character of the Policy, the right of the Company to decline, renew or cancel the Policy and the terms upon which renewal is offered.
iii) If a claim is made in the Period of Insurance where a cumulative bonus has been applied, then the increased Limit of Indemnity applicable will be reduced by 10% of the Sum Insured at immediate next renewal of the Policy.
(iv) The cumulative bonus shown in the Policy is provisional and it is subject to revision in the event of any claim under the earlier Policy being reported after the issuance of this Policy.
(v) The entire cumulative bonus shall be lost if the policy is not renewed with the Company within 15 days of expiry of the previous policy.

Extension HC 27– Pre-existing Illness coverage

Notwithstanding anything to the contrary contained in the Policy, the scope of cover under Benefit 'A' is extended to cover Pre-existing Illnesses, subject to the following conditions:

(i) The Insured has taken the TAX GAIN - Health Advantage Plus Policy from the Company and has been covered under such TAX GAIN - Health Advantage Plus Policy, without a break, for 2 consecutive years immediately preceding the Period of Insurance;
(ii) The Pre-existing Illnesses have been declared by the Insured and accepted by the Company in writing for the first TAX GAIN - Health Advantage Plus Policy issued by the Company in favour of the Insured (as specified in (I) above);
(iii) The Permanent Exclusions mentioned under sub-clause 2.2 (iv) of Part II of the Policy shall not be covered under Benefit A in any case;
(iv) The liability of the Company shall be subject to the Limit of Indemnity;
(v) Notwithstanding anything in clause (iv) above, if the Policy is renewed for an enhanced Sum Insured, then the benefit in respect of the Pre-existing Illnesses shall be restricted to the Sum Insured that is lowest under the prior Policies as specified in (I) above.

Endorsement HC 28a– Sub-limit on Medical Surgery/Procedures

Notwithstanding anything to the contrary stated here in above or in the policy, the Company's maximum liability to make payment for an admissible claim (including its related Pre and Post Hospitalization expenses if applicable), under Benefit A arising due to the below mentioned Illness or procedure or a medical charge shall, subject always to the Limit of Indemnity, be as per table below:

Name of Illness / procedure	Sub-limit (Rs)
Cataract (Each Eye)	20000

EXTENSIONS/ENDORSMENTS APPLICABLE TO BENEFIT B

Extension OP 01: Floater Benefit

Floater Benefit means the aggregate Sum Insured as specified for a particular Insured under Benefit 'B' and the members of his/her Immediate Family as covered under the Policy, is available for any or all the members of his/her Immediate Family for one or more claims during the tenure of the Policy. The payment by the Company will be limited to the aggregate Sum Insured for the Insured under Benefit 'B' and the members of his/her Immediate Family, for any and all claims made under the Policy subject always to the Limit of indemnity. For the purpose of this extension the term "Immediate Family" shall include Policyholder's lawful spouse, dependent children, and parents whose name(s) are specifically appearing in Part I of the Schedule to this Policy. Notwithstanding anything stated here in above, the Company shall compensate the Insured for any and all claims made by the Insured under the Floater Benefit, only when such a claim made by the Insured is admissible under Benefit "B"

Extension OP 02 – Domiciliary Treatment

Notwithstanding anything to the contrary stated herein, the cover under Benefit 'B' is extended to cover all medical charges incurred under a written advice of a Medical Practitioner.

Mailing Address : ICICI Lombard General Insurance Company Limited, 4th, Floor, Interface -11, Office No. 401 & 402, New Linking Road, Malad (W), Mumbai - 400 064.
Corporate Office : ICICI Lombard General Insurance Company Limited, Zenith House, Keshavrao Khadye Marg, Opp. Race Course, Mahalaxmi, Mumbai - 400 034.

Insurance is the subject matter of the solicitation. IRDA Reg. No. 115, Misc 63

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