PART B

Definitions

Words or phrases appearing in the Policy Document in initial capitals will have the meanings given to them below:

Where appropriate, any reference to the singular includes references to the plural, references to the male include references to the female and references to any statute include references to any subsequent changes to that statute.

In case of any conflict between the interpretations of any of the terms of this Policy Document, the Part C (Specific Terms and Conditions) shall override Part B (Definitions) of this Policy Document.

General Terms

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

Age means age at last birthday at the Coverage Commencement Date.

Application Form means the proposal form and any other information given by the Master Policyholder to the Company before the inception of this Policy.

Appointee means the person named in the Membership Register who has been nominated by the Insured Member to receive payment, under this Policy if the Nominee(s) is/are a minor(s) when the payment becomes due.

Benefit Schedule means the table of benefits specific to an Insured Member stating the amount of benefit payable and is an integral part of the Certificate of Insurance.

Certificate of Insurance means the certificate issued to each Insured Member to confirm his/her coverage under the Policy.

Claimant means the Nominee(s) named by the Insured Member in the Membership Register and in the absence of the Nominee, the legal heir(s) of the deceased Insured Member.

Coverage Commencement Date means the date on which insurance coverage in respect of an Insured Member commences, as specified in the Certificate of Insurance.

Coverage Expiry Date means the date on which coverage for the Insured Member ends as specified in the Certificate of Insurance.

Coverage Sum Insured means the amount calculated in accordance with the Certificate of Insurance which is payable on the occurrence of an insured event in respect of an Insured Member.

Coverage Term means the period between the Coverage Commencement Date and Coverage Expiry Date as specified in the Certificate of Insurance.

Credit Account Statement means a statement obtained from the Master Policyholder by the Company in respect of the Insured Member to whom/ whose Nominee/ legal heir, the claim money is payable on happening of any contingency under this Policy, with, *inter alia*, the following details:

a) Name of the Group Master Policyholder.
b) Group master policy number.
c) Name of Insured Member.
d) Coverage Commencement Date.
e) Coverage Sum Insured.
f) Original amount of loan.
g) Particulars of the recoveries made by the Master Policyholder towards the loan.
h) Outstanding loan balance as on the date of occurrence of the contingent event covered.
i) Balance claim amount *(difference between the Coverage Sum Insured referred under above and outstanding loan balance referred under (h) above)* payable to the Insured Member on the occurrence of the contingent event or to the Nominee/ legal heirs of the deceased Insured Member in case of death.
j) Declaration/ undertaking of the Master Policyholder that the information/ details furnished in the Credit Account Statement are verified for accuracy.
k) Where the claim discharge form of the Insured Member / Nominee/ Claimant is obtained through the Master Policyholder, the Company shall take a certification either in the claim discharge form or in a separate format from the Master Policyholder that the Insured Member/ Nominee/ Claimant who had submitted the claim discharge form is the same person who has been registered by the Master Policyholder as the Insured Member/ Nominee/ Claimant under the Policy.

Eligible Member means a person who satisfies and continues to satisfy the eligibility criteria specified in the scheme rules and who may apply to become an Insured Member.

Guaranteed Surrender Value means an amount which is calculated as follows:

60% of the Single Premium received in respect of the Insured Member (excluding applicable taxes, if any) * (Unexpired Coverage Term in completed months / Total Coverage Term in months) * (Coverage In-force / initial Coverage Amount)^.

^In case of flat cover or cover as multiple of EMI, (Coverage In-force / initial Coverage Amount) factor will be construed 1 (one).

Where, **Coverage In-force** means the benefit amount as per the Benefit Schedule as on the monthly plan anniversary immediately before the date of surrender of the cover under the Policy.

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 (Registrations and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) & the said Act OR complies with all minimum criteria as under:
• has qualified nursing staff under its employment round the clock;
• has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
• has qualified medical practitioner(s) in charge round the clock;
• has a fully equipped operation theatre of its own where surgical procedures are carried out;
• maintains daily records of patients and makes these accessible to the insurer's authorized personnel.

Illness means a sickness or a disease or 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:
1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests;
2. it needs ongoing or long-term control or relief of symptoms;
3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it;
4. it continues indefinitely;
5. it recurs or is likely to recur.

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

Insured Member means an Eligible Member who is enrolled under the Policy and whose name has been recorded in the Membership Register after due approval from the Company and to whom a Certificate of Insurance has been issued.

IRDAI means the Insurance Regulatory and Development Authority of India.

Master Policyholder means the person named in the Schedule who has concluded this Policy with the Company with respect to Insured Members.

Medical Advice - Any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

Medical Practitioner means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of his license. The Medical Practitioner shall not include: a) A close relative of the policyholder; or b) A person who resides with the policyholder; or c) A person covered under this Policy.

Membership Register means the register maintained by the Master Policyholder containing details of each Insured Member, including but not limited to name, age, sex, Benefit Schedule, Nominee(s) (and Appointee if the Nominee is a minor(s)) details, the Coverage Commencement Date, Single Premium received and any special conditions applicable to the Insured Member.

Notification of Claim means the process of intimating a claim to the insurer through any of the recognized modes of communication.

Nominee means the person named in the Membership Register who has been nominated by the Insured Member in accordance with Section 39 of the Insurance Act 1938 as amended from time to time to receive the benefits.

Pre-existing Disease means any condition, ailment or injury or disease:
a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement or
b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.

Policy Anniversary means the annual anniversary of the Policy Commencement Date.

Policy Commencement Date means the date when this Policy is issued and is specified in the Schedule.

Policy or Policy Document means these Standard Terms & Conditions, the Application Form, scheme rules, the Schedule and Certificates of Insurance, as amended from time to time.

Policy Year means the 12 months period starting from the Policy Commencement Date and accordingly thereafter every subsequent Policy Anniversary.

Schedule means the document attached to this Policy which contains specific details of the Policy and benefit details and any annexure attached to it from time to time and any endorsements the Company has made and, if more than one, then the latest in time.

Single Premium means the amount specified in the Schedule received for the insurance coverage of the Insured Member prior to the Coverage Commencement Date.

Surgery or Surgical Procedure means manual and/ or operative procedure(s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or day care centre by a *Medical Practitioner*.

Survival Period means a period of 14 days from the first diagnosis of a Critical Illness listed below, unless a separate Survival Period is specified for any particular disease/condition. The diagnosis of the Critical Illness must be made peri-mortem (i.e. while the life insured is still alive).

Waiting Period means a period of 90 days (or such other period specified in the Policy for a particular disease/condition) from the Coverage Commencement Date during which no benefits will be available on the occurrence of the insured event unless the insured event arises solely and directly due to an Accident.

Definitions – pertaining to Critical Illnesses

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

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

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

Blindness means Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident. The Blindness is evidenced by:
• corrected visual acuity being 3/60 or less in both eyes or;
• the field of vision being less than 10 degrees in both eyes.
The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure.

Brain Surgery - Aneurysm or ballooning of a part of the wall of a blood vessel in the brain that is serious enough to warrant corrective surgery. Benefit shall only be payable on the actual undergoing of surgery to the brain under general anesthesia during which craniotomy is performed. Treatment by micro coil thrombosis or balloon embolisation alone is excluded. Burr hole procedures, transphenoidal procedures and other minimally invasive procedures are also excluded.

Cancer - A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma. The following are excluded:
• 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;
• Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
• Malignant melanoma that has not caused invasion beyond the epidermis;
• 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;
• All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
• Chronic lymphocytic leukaemia less than RAI stage 3;
• Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification;• 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;

Coma of specified severity shall mean 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:
• no response to external stimuli continuously for at least 96 hours;
• life support measures are necessary to sustain life; and
• permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.
The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

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

End Stage Liver Failure - Permanent and irreversible failure of liver function that has resulted in all three of the following:
• Permanent jaundice; and
• Ascites; and
• Hepatic encephalopathy.
Liver failure secondary to drug or alcohol abuse is excluded.

End Stage Lung Failure - End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:
• FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
• Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
• Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less ($PaO_2 < 55mmHg$); and
• Dyspnea at rest.

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

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

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

Loss of Speech means total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an ENT specialist.

Major Organ/Bone Marrow Transplant means the actual undergoing of a transplant of:
• One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ; or
• Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

The following are excluded:
• Other stem-cell transplants;
• Where only islets of langerhans are transplanted.

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

Multiple Sclerosis with Persisting Symptoms means the unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
• Investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
• There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.
Neurological damage due to SLE is excluded.

Open Chest CABG shall mean 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:
Angioplasty and/or any other intra-arterial procedures.

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

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

Stroke resulting in Permanent Symptoms means any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

The following are excluded:
• Transient ischemic attacks (TIA);
• Traumatic injury of the brain;
• Vascular disease affecting only the eye or optic nerve or vestibular functions.

Surgery of Aorta shall mean the actual undergoing of surgery via thoracotomy or laparotomy to repair or correct an aortic aneurysm, an obstruction of the aorta, a coarctation of the aorta or a traumatic rupture of the aorta. For the purpose of this definition aorta shall mean the thoracic and abdominal aorta but not its branches. There must have been excision and replacement of a portion of diseased aorta with a graft. The term “aorta” means the thoracic and abdominal aorta but not its branches. Stent-grafting is not covered.

Third Degree 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.

PART C
Specific Terms and Conditions

Section One: Membership Provisions

An Eligible Member will become an Insured Member only when the Master Policyholder has entered the Eligible Member's details into the Membership Register and the Company has issued a Certificate of Insurance. The Insured Member's coverage under the Policy shall commence from the Coverage Commencement Date as specified in the Certificate of Insurance and the Membership Register.

The Master Policyholder is responsible for maintaining the Membership Register and for ensuring that it is accurate. The Master Policyholder shall, within 7 days from the commencement of each calendar month, send an updated list of Insured Members appearing in the Membership Register in the foregoing calendar month. The Master Policyholder agrees to indemnify and hold the Company harmless from and against any and all losses, costs, expenses, actions or proceedings suffered by the Company in relation to any error or deficiency in or in respect of the Membership Register.

The Company may seek additional information and/ or documentation in respect of any Insured Member at any time. If the information and/ or documentation for such Insured Member is not received by the Company within 30 days of a request being sent to the Master Policyholder, the name of the Insured Member shall be deemed to have been removed from the Membership Register with immediate effect and the Certificate of Insurance issued shall no longer be valid.

Section Two: Payment of Premium

The Single Premium shall be deemed to have been paid only when it has been received and realized by the Company with respect to such Insured Member.

Section Three: Benefits

Coverage Sum Insured Options:

The Schedule and Certificate of Insurance will specify which of the following Coverage Sum Insured options is in force for the Insured Member under this Policy:

Option A: The Coverage Sum Insured will be the fixed amount specified in the Certificate of Insurance throughout the Coverage Term;
Option B: The Coverage Sum Insured will reduce during the Coverage Period in accordance with the Benefit Schedule. If Option B is in force for the Insured Member, then the Coverage Sum Insured payable on the occurrence of the insured event will be the reduced amount specified in the Benefit Schedule and not the original sum insured amount applicable on the Coverage Commencement Date. This Option B can be availed only if the Policy Term is 2 years or more.

Claim Payments:

For non-lender borrower schemes and lender borrower schemes with entities other than listed below:

On the occurrence of an insured event in respect of an Insured Member, the amount due under the Policy will be payable to the Claimant.

For lender borrower schemes with regulated entities:

If the Policy is issued under lender-borrower category to any of the entities listed below as specified in the Schedule, the Insured Member shall have the option to issue an authorization in favour of the Company to the effect that in case of an insured event during the Coverage Term, the claim amount, if any, payable under the Policy shall first be utilized for payment to the Master Policyholder to the extent of the outstanding loan amount as specified in the Credit Account Statement and the balance amount, if any, payable under the Policy will be payable to the Claimant. If the Insured Member does not make any such authorization, the entire claim amount would be paid to the Claimant on the occurrence of the insured event.

1. Reserve Bank of India (RBI) regulated Scheduled Commercial Banks (including Co-operative Banks),
2. NBFC's having certificate of registration from RBI,
3. National Housing Bank (NHB) regulated Housing Finance Companies,
4. National Minority Development Finance Corporation (NMDFC) and its State Channelizing Agencies, and
5. Small Finance Banks regulated by RBI.
6. Mutually Aided Cooperative Societies formed and registered under the applicable State Act concerning such Societies
7. Microfinance companies register under section 8 of the Companies Act, 2013
8. Any other category as approved by the Authority.

Coverage Options

The following Coverage Options are available under the Policy. The Certificate of Insurance shall specify the Coverage Option that is in force for the Insured Member.

Option I: Accidental Death Cover
If the Insured Member's death occurs solely and directly due to an Accident which occurs during the Coverage Term, the Coverage Sum Insured will be payable provided that the Insured Member's death occurs within 180 days of the Accident. On the Insured Member's death, all benefits under the Policy shall cease in respect of the Insured Member.

Option II: Critical Illness Cover
If the Insured Member is first diagnosed to be suffering from a Critical Illness (listed above) during the Coverage Term and after the completion of the Waiting Period, the Coverage Sum Insured will be payable provided that the Insured Member is alive on the expiry of the Survival Period. On payment of the Coverage Sum Insured, all benefits under the Policy shall cease in respect of the Insured Member.

Option III: Accidental death plus Accidental Permanent, Total or Partial Disability (ATPD) Cover

If the Insured Member's death or permanent total disability or permanent partial disability occurs solely and directly due to an Accident which occurs during the Coverage Term, the percentage of the Coverage Sum Insured calculated in accordance with the table below will be payable provided that the Insured Member's death or permanent total disability or

permanent partial disability (as applicable) occurs within 180 days of the Accident.

The Company shall deduct claim amounts already paid under this Option III in respect of the Insured Member from any further claims which become payable under this Option III in respect of the Insured Member during the Coverage Term. If 100% of the Coverage Sum Insured has not been paid under this Option III, the Insured Member's cover under the Policy shall continue for the Insured Member to the extent of the remaining Coverage Sum Insured amount:

Insured Events	% of Coverage Sum Insured
Accidental Death	100%
Loss of use of both hands	100%
Loss of use of both feet	100%
Loss of sight in both eyes	100%
Loss of use of one hand and one foot	100%
Loss of use of one hand and loss of sight in one eye	100%
Loss of use of one foot and loss of sight in one eye	100%
Loss of speech and loss of hearing in both ears	50%
Loss of hearing in both ears	25%
Loss of speech	25%
Loss of use of one hand	25%
Loss of use of one foot	25%
Loss of sight in one eye	25%

For the purpose of this table:

i. Loss of use by physical severance of a hand or foot means severance of the hand at or above the wrist, and of the foot at or above the ankle.

ii. Loss of use or Loss of sight means total paralysis of one or more limb (hand or foot above the wrist and ankle, respectively), or loss of vision respectively, which is certified in writing by a Medical Practitioner to be permanent, complete and irreversible and substantiated by physical examination and investigation to be permanent, complete and irreversible.

For accidental permanent total or partial disability benefit to be payable, such disability must have persisted for at least 180 days and must, in the opinion of a registered independent medical practitioner, be deemed permanent. Except for physical severance where the benefit would be payable immediately.

Option-IV: Accidental Death plus Critical Illness Cover

If the Insured Member is first diagnosed to be suffering from a Critical Illness (listed above) during the Coverage Term and after the completion of the Waiting Period, the Coverage Sum Insured will be payable provided that the Insured Member is alive on the expiry of the Survival Period.

In addition, if the Insured Member's death occurs solely and directly due to an Accident which occurs during the Coverage Term, the Coverage Sum Insured will be payable in addition to the amount already paid under this Option-IV provided that the Insured Member's death occurs within 180 days of the Accident.

On the Insured Member's death, all benefits under the Policy shall cease in respect of the Insured Member.

The Critical Illness benefit will be payable only once during the Coverage Term in respect of the Insured Member.

Option-V: Accidental Death plus Accidental Permanent, Total or Partial Disability plus Critical Illness Cover

If the Insured Member is first diagnosed to be suffering from a Critical Illness (listed above) during the Coverage Term and after the completion of the Waiting Period, the Coverage Sum Insured will be payable provided that the Insured Member is alive on the expiry of the Survival Period.

In addition, if the Insured Member's death or permanent total disability or permanent partial disability occurs solely and directly due to an Accident which occurs during the Coverage Term, the percentage of the Coverage Sum Insured calculated in accordance with the table below will be payable provided that the Insured Member's death or permanent total disability or permanent partial disability (as applicable) occurs within 180 days of the Accident.

The Critical Illness benefit will be payable only once during the Coverage Term in respect of the Insured Member.

In respect of the accidental death and disablement cover, the Company shall deduct claim amounts already paid under this Option V in respect of the Insured Member in accordance with the table below from any further claims which become payable under this Option V in accordance with the table below in respect of the Insured Member during the Coverage Term. If 100% of the Coverage Sum Insured has not been paid under this Option V in accordance with the table below, the Insured Member's cover under the Policy shall continue for the Insured Member to the extent of the remaining Coverage Sum Insured amount:

Insured Events	% of Coverage Sum Insured
Accidental Death	100%
Loss of use of both hands	100%
Loss of use of both feet	100%
Loss of sight in both eyes	100%
Loss of use of one hand and one foot	100%
Loss of use of one hand and loss of sight in one eye	100%
Loss of use of one foot and loss of sight in one eye	100%
Loss of speech and loss of hearing in both ears	50%
Loss of hearing in both ears	25%
Loss of speech	25%
Loss of use of one hand	25%
Loss of use of one foot	25%
Loss of sight in one eye	25%

For the purpose of this table:

i. Loss of use by physical severance of a hand or foot means severance of the hand at or above the wrist, and of the foot at or above the ankle.
ii. Loss of use or Loss of sight means total paralysis of one or more limb (hand or foot above the wrist and ankle, respectively), or loss of vision respectively, which is certified in writing by a Medical Practitioner to be permanent, complete and irreversible and substantiated by physical examination and investigation to be permanent, complete and irreversible.

For accidental permanent total or partial disability benefit to be payable, such disability must have persisted for at least 180 days and must, in the opinion of a registered independent medical practitioner, be deemed permanent. Except for physical severance where the benefit would be payable immediately.

Under Option III & V, the ADB & ATPD Sum Insured shall always be equal only at the inception of the Policy. Subsequently, the benefits payable under ATPD for the different insured events can be at 25%, 50%, etc. of the chosen ATPD Sum Insured at policy inception

Section Four: Full Pre-payment of loan

I. Full Pre-payment of loan

On full prepayment of the loan, the Insured Member may choose any of the following options, based on the applicable terms and conditions as under:

(a) **Cover Continuation**: The Insured Member will continue to be covered under this Policy, as per the existing terms and conditions and original Benefit Schedule.

(b) **Surrender**: The Insured Member may request for surrender of his membership in which case the Insured Member's coverage under this Policy will terminate and the applicable Guaranteed Surrender Value will be paid to the Insured Member.

II. Partial Pre-payment of loan

On partial payment of the loan, the Insured Member's coverage shall continue as per the existing terms and conditions and original Benefit Schedule.

Section Five: Exclusions

General exclusions applicable to Critical Illness Benefit:

No benefits will be payable under this Policy if a claim or event suffered by the insured member is directly or indirectly caused or exacerbated as a result of any of the following:

- Pre-Existing condition(s) - for 4 years from date of commencement/reinstatement, whichever is later.
- Deliberate or intentional failure to seek or follow Medical Advice.
- Self-inflicted injury, suicide or attempted suicide, whether sane or insane.
- An act of any person acting on their own or on behalf of or in connection with any group or organization to influence by force any group, corporation or government by terrorism, kidnapping or attempted kidnapping, attack, assault, or any other violent means.
- Under the influence or abuse of drugs, alcohol, narcotics or psychotropic substance not prescribed by a registered Medical Practitioner.
- Participation in any armed force or peace keeping activities
- War or hostilities (whether war be declared or not), civil war, rebellion, revolution, civil unrest or riot wherein the Insured Member is an active participant in such activities.
- Deliberate participation of the Insured Member in an illegal or criminal act with criminal intent.
- Nuclear fusion, nuclear fission, nuclear waste or any radioactive or ionising radiation.

General Exclusions applicable to ADB and ATPD Benefits:

Death or Disability arising directly or indirectly from any of the following are specifically excluded:
- The Insured Member taking part in any hazardous sport or pastimes (including hunting, mountaineering, motor racing, steeple chasing, bungee jumping, paragliding, deep sea diving etc.).
- The Insured Member flying in any kind of aircraft, other than as a bonafide passenger (whether fare-paying or not) on an aircraft of a licensed airline.
- Self-inflicted injury, suicide or attempted suicide-whether sane or insane.
- An act of any person acting on their own or on behalf of or in connection with any group or organization to influence by force any group, corporation or government by terrorism, kidnapping or attempted kidnapping, attack, assault, or any other violent means.
- Under the influence or abuse of drugs, alcohol, narcotics or psychotropic substance not prescribed by a registered Medical Practitioner. However, this exclusion shall not apply in the circumstances where the insured is directly or indirectly not responsible for the accident though under influence of intoxication, such as when the insured is travelling as a passenger.
- Participation in any armed force or peace keeping activities.
- War or hostilities (whether war be declared or not), civil war, rebellion, revolution, civil unrest or riot wherein the Insured Member is an active participant in such activities.
- Deliberate participation of the Insured Member in an illegal or criminal act with criminal intent.
- Nuclear fusion, nuclear fission, nuclear waste or any radioactive or ionising radiation.

PART D

Policy Servicing

Section One: Free Look Period

The Master Policyholder/ Insured Member will have a period of 15 days from the date of receipt of the Policy Document/ Certificate of Insurance to review the terms and conditions of the Policy. If the Master Policyholder/ Insured Member disagrees to any of those terms or conditions, he/she has an option to cancel the Policy/ Certificate of Insurance stating the reasons for his/her objection. The Master Policyholder/ Insured Member shall be entitled to a refund of the Premium paid subject to a deduction of a proportionate risk premium for the period of risk cover, any expenses incurred by the Company towards medical examination and the stamp duty charges.

Section Two: Surrender of Policy

The Master Policyholder can surrender the Policy by giving 90 days' notice in writing to the Company.

The Insured Member can exercise any of the options as mentioned in sub-section (I) of Section Six of Part C – Full Pre-payment of loan. The Insured Members who choose cover continuation option will be serviced by the Company till their coverage is terminated.

Section Three: Maturity Benefit

No maturity benefits are payable under this Policy.

Part E

Charges - Nil

Part F
General Terms and Conditions

Section One: Termination of the Policy

An Insured Member's coverage under the Policy shall immediately and automatically terminate on the occurrence of the first of the following events:

a) Coverage Expiry Date;
b) Payment of ADB as applicable;
c) Payment of ATPD benefit (on payment of 100% of Coverage Sum Insured)/ Critical Illness benefit as applicable;
d) Date of receipt of valid surrender request from the Insured Member by the Company through Master Policyholder;
e) The Insured Member ceases to fulfill any of the eligibility criteria.

Either the Company or the Master Policyholder shall have the right to terminate the Master Policy for new business by giving a prior written notice of 30 days in case of any of the following:
a. Wherein the Terms & Conditions are not agreed by the Master Policyholder.
b. Wherein the Company decides not to write any new business under this product.

Section Two: Claim Processing

In order for the Company to make any payment under the Policy that it is necessary that the Master Policyholder:

a) Immediately notifies the Company of the Insured Member's Accidental death or ATPD or critical illness in writing, and in any event within 30 days of Accidental death or ATPD or critical illness. Company may condone the delay in filing a claim beyond 30 days where the claimant can establish that the delay was due to unforeseen circumstances and beyond the control of the Claimant.

b) Provides the Company with the opportunity of establishing to its satisfaction that a claim is payable.

c) Provides all reasonable cooperation and any documentation and information to the Company, including but not limited to:

   i. The claim form duly completed and countersigned by the authorized signatory of Master Policyholder.

   ii. The Certificate of Insurance.

   iii. Evidence of Insured Member's date of birth if the Company has not admitted the Age of the Insured Member.

   iv. The original or a legalized copy of the Insured Member's death certificate showing the circumstances, cause and the date of death.

   v. First Information Report or Police inquest report for any claim arising due to an accident.

   vi. Attending physician's statement.

   vii. Attested True Copy of Indoor Case papers of the Hospital(s).

   viii. Discharge summary of present and past Hosplitalizations.

   ix. First consultation and Follow-up consultation notes.

   x. Diagnosis certificate from specialist.

   xi. Authorization/Consent Letter to collect medical records from Hospital.

   xii. Employer certificate, if employed.

   xiii. All medical examination reports, including:

      (a) Laboratory test report;
      (b) X-Ray/CT Scan/MRI reports & plates;
      (c) Ultrasonography report;
      (d) Histopathology report;
      (e) Clinical/Hospital reports;
      (f) Any other investigation report, if any;
      (g) Treatment papers (chemotherapy, radiotherapy etc.);
      (h) Employer certificate, leave records, medical certificate and mediclaim details;
      (i) Attested certificate by medical specialist with exact diagnosis along with staging and grading and the treatment undergone for which claim is made;
      (j) The original or certified copies of diagnosis of illness/disability by a qualified Medical Practitioner.

   xiv. A duly signed and verified Credit Account Statement to the Company in the prescribed format (if any).

   Treating doctor outside India should be a Medical Practitioner registered in that country as approved by the Company. Claims documents from outside India are only acceptable in English language unless specifically agreed otherwise, and duly authenticated.

   The Company may, on a case to case basis and subject to exceptional circumstances, condone the submission of any of the above mentioned documents/ information while processing the claim.

   The Master Policyholder shall certify in the claim discharge form to the effect that the Insured Member/ Nominee(s)/ beneficiary who has submitted the claim discharge form is the same person who has been registered with the Master Policyholder as the Insured Member/ Nominee(s)/ beneficiary.

Claim Settlement:

i. On receipt of the last necessary document(s) the Company shall within a period of thirty days offer a settlement of the claim to the insured.

ii. If the Company, for any reasons, rejects a claim, it shall communicate to the insured in writing within a period of thirty days from the receipt of the last necessary document(s).

iii. In case of delay in the payment, the Company shall pay interest at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

iv. In case where the circumstances of a claim warrant an investigation; same will be initiated and completed within 30 days from the date of receipt of last necessary document. In such cases, claim settlement will be done within 45 days from the date of receipt of last necessary document.

v. In case of delay in the payment beyond stipulated 45 days, the Company shall pay interest at a rate of 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

Section Three: Nomination

The provisions of nomination are governed by Section 39 of the Insurance Act, 1938, as amended from time to time.

A leaflet containing the simplified version of the provisions of Section 39 of the Insurance Act 1938 as amended from time to time is enclosed as Annexure B for reference.

Section Four: Assignment

Assignment is allowed as per Section 38 of the Insurance Act, 1938 as amended from time to time.

A leaflet containing the simplified version of the provisions of the above section is enclosed in Annexure A– for reference.

Section Five: Miscellaneous

a) Audit and Certification

The Company reserves the right to conduct an audit of Master Policyholder, either directly or through its representatives, to establish the accuracy of the Credit Account Statements furnished by the Master Policyholder. The Company may seek an annual certificate from the statutory / internal auditors of the Master Policyholder, in the prescribed format, confirming the accuracy of the Credit Account Statements issued by the Master Policyholder in the preceding financial year as per the applicable terms and condition of the loan. The Master Policyholder shall compensate the Company for any loss incurred by the Company due to submission of inaccurate Credit Account Statements by the Master Policyholder.

b) Loss of the Policy Document

i) If the Policy Document is lost or destroyed then the Company reserves the right to make such investigations into and call for such evidence of the loss of the Policy Document, at the Master Policyholder's expense, as the Company considers necessary before issuing a duplicate Policy Document.

ii) If the Company agrees to issue a duplicate Policy Document then:

1. The Master Policyholder agrees to first pay an amount not exceeding Rs 500/- towards the Company's fee for the issue of a duplicate and applicable stamp duty charges, and

2. The original Policy Document will cease to be of any legal effect and the Master Policyholder shall indemnify and keep the Company indemnified and hold the Company harmless from and against any costs, expenses, claims, awards or judgments arising out of or howsoever connected to the original Policy Document.

iii) If the Certificate of Insurance is lost or destroyed, then the Company reserves the right to make such investigations and call for such evidence of the loss of the Certificate of Insurance as the Company considers necessary before issuing a duplicate Certificate of Insurance. The original Certificate of Insurance will cease to be of any legal effect after issuance of the duplicate Certificate of Insurance and the Insured Member shall indemnify and keep the Company indemnified and hold the Company harmless from and against any costs, expenses, claims, awards or judgments arising out of or howsoever connected to the original Certificate of Insurance.

c) Notices

i. All notices meant for the Company whether under this Policy or otherwise must be in writing and delivered to the Company at the specified address.

ii. All notices meant for the Master Policyholder will be in writing and will be sent by the Company to the Master Policyholder's address shown in the Schedule or any such other address as may be communicated to the Company by the Insured Member.

iii. The Company shall not be responsible for any consequences related to or arising out of non-intimation of changes to the Master Policyholder's or Insured Member's address. Failure in timely notification of change of address could result in a delay in processing of benefits payable under the Policy.

d) Misstatement of Age

If the correct age of the Insured Member is different from that mentioned in the Application Form, the Company will assess the eligibility of the Insured Member for the Policy in accordance with the correct age of the Insured Member.

If on the basis of correct age, the Insured Member is not eligible for the Policy, the Policy shall be cancelled immediately after refunding the Single Premium received by the Company under the Policy as per the provisions of Section 45 of Insurance Act as amended from time to time.

If the Age of the Insured Member is higher than the Age specified in the Application Form, the Company will decrease the Coverage Sum Insured and other benefits based on the correct age of Insured Member.

If the Age of the Insured Member is lower than the Age specified mentioned in the Application Form, the Company will refund the excess premium received (without interest) under the Policy based on the correct age of Insured Member.

e) Currency & Territorial Limits

All Single Premium and any amounts payable under the Policy are payable within India, and in the currency of the Policy as specified in the Schedule.

f) Taxes

In respect of any payment made or to be made under this Policy, the Company shall deduct or charge taxes taxes including Goods and Services tax as applicable and other levies as applicable from time to time, at such rates as notified by the Government of India or a body authorised by the Government of India from time to time.

g) Governing Law & Jurisdiction

Any and all disputes or differences arising out of or in respect of this Policy shall be governed by and determined in accordance with Indian law and shall be subject to the jurisdiction of Indian Courts.

h) Entire Contract & Agent's Authority

The Policy Document comprises the entire contract between the Master Policyholder and the Company, and it cannot be changed or altered unless the Company approves of it in writing by endorsement on the Schedule and, where required, the approval of the IRDAI has been obtained.

The insurance agent is authorised to arrange the completion and submission of the Master Policyholder's Application Form. No insurance agent is authorised to amend the Policy Document, or to accept any notice on the Company's behalf or to accept payments on the Company's behalf. If any money meant for the Company in any form is paid to an insurance agent then such payment is made at the Master Policyholder's risk and the agent will be acting only as the Master Policyholder's representative.

i) Fraud and Misstatement - Section 45 of the Insurance Act, 1938

Fraud and misstatement shall be dealt with in accordance with Section 45 of the Insurance Act, 1938, as amended from time to time. A Leaflet containing the simplified version of the provisions of Section 45 of the Insurance Act 1938 as amended from time to time is enclosed as Annexure C for reference.

PRAMERICA LIFE GROUP HEALTH KAVACH
(NON-LINKED NON-PARTICIPATING FIXED BENEFIT GROUP HEALTH PRODUCT)

PART G
Other Details

Grievance Redressal

I) In case of any clarification or query please contact your Company Salesperson. Any concern may also be raised at any of the branch offices of the Company, the addresses of the branch offices are available on the official website of the company.

II) The Company may be contacted at:

Customer Service Help Line: 1800-102-7070 (Toll Free)
(9.30 am to 6.30 pm from Monday to Saturday)
Email : contactus@pramericalife.in
Email for Senior Citizen:
seniorcitizen@pramericalife.in
Website: www.pramericalife.in

Communication Address : Customer Service,
Pramerica Life Insurance Ltd.,
4th Floor, Building No. 9 B, Cyber City,
DLF City Phase III, Gurgaon– 122002
Office hours: 9.30 am to 6.30 pm from Monday to Friday

III) Grievance Redressal Officer :
If the response received from the Company is not satisfactory or no response is received within two weeks(Business Days) of contacting the Company, the matter may be escalated to:

Email- customerfirst@pramericalife.in

Grievance Redressal Officer
Pramerica Life Insurance Ltd.,
4th Floor, Building No. 9 B, Cyber City,
DLF City Phase III, Gurgaon– 122002

GRO Contact Number: 0124 - 4697069
Office hours: 9.30 am to 6.30 pm from Monday to Friday

IV) IRDAI - Grievance Redressal Cell:
If after contacting the Company, the Policyholders query or concern is not resolved satisfactorily within 15 days , the Grievance Redressal Cell of the IRDAI may be contacted.

Call Center Toll Free number – 155255
Email Id- complaints@irdai.gov.in

Complaints against Life Insurance Companies:
Insurance Regulatory and Development Authority of India

Consumer Affairs Department
Insurance Regulatory and Development Authority of India
Sy. No. 115/1
Financial District
Nanakramguda, Gachibowli
Hyderabad , Telangana – 500032
Tel: 040 - 20204000

V) Insurance Ombudsman:

The office of the **Insurance Ombudsman** has been established by the Government of India for the redressal of any grievance in respect of life insurance policies.

Any person who has a grievance against an insurer, may himself or through his legal heirs, nominee or assignee, make a complaint in writing to the Insurance Ombudsman within whose territorial jurisdiction the branch or office of the insurer complained against or the residential address or place of residence of the complainant is located.

The complaint shall be in writing, duly signed by the complainant or through his legal heirs, nominee or assignee and shall state clearly the name and address of the complainant, the name of the branch or office of the insurer against whom the complaint is made, the facts giving rise to the complaint, supported by documents, the nature and extent of the loss caused to the complainant and the relief sought from the Insurance Ombudsman.

You may approach the Insurance Ombudsman if your grievance pertains to any of the following:

a. Delay in settlement of claim beyond the time specified in the regulations, framed under the Insurance Regulatory and Development Authority of India Act, 1999
b. Any partial or total repudiation of claims
c. Disputes over premium paid or payable in terms of insurance policy
d. Misrepresentation of policy terms and conditions
e. Legal construction of insurance policies in so far as the dispute relates to claim
f. Policy servicing related grievances against insurers and their agents and intermediaries
g. Issuance of Life insurance policy, which is not in conformity with the proposal form submitted by the proposer
h. Non-issuance of insurance policy after receipt of premium
i. Any other matter resulting from the violation of provisions of the Insurance Act, 1938 or the regulations, circulars, guidelines or instructions issued by the IRDAI from time to time or the terms and conditions of the policy contract, in so far as they relate to issues mentioned at clauses (a) to (f)

No complaint to the Insurance Ombudsman shall lie unless

(a) The complainant makes a written representation to the insurer named in the complaint and—
(i) Either the insurer had rejected the complaint, or
(ii) The complainant had not received any reply within a period of one month after the insurer received his representation, or
(iii) The complainant is not satisfied with the reply given to him by the insurer
(b) The complaint is made within one year—
(i) After the order of the insurer rejecting the representation is received, or
(ii) After receipt of decision of the insurer which is not to the satisfaction of the complainant, or
(iii) After expiry of a period of one month from the date of sending the written representation to the insurer if the insurer named fails to furnish reply to the complainant.

The address of the Insurance Ombudsman are attached herewith and may also be obtained from the following link on the internet

Link: http://www.cioins.co.in/ombudsman.html

PRAMERICA LIFE GROUP HEALTH KAVACH
(NON-LINKED NON-PARTICIPATING FIXED BENEFIT GROUP HEALTH PRODUCT)

Address & Contact Details of Ombudsmen Centers

Council for Insurance Ombudsmen
(Monitoring Body for Offices of Insurance Ombudsman)
3rd Floor, Jeevan Seva Annexe, S.V Road , Santacruz(West), Mumbai – 400054. Tel no: 022-69038801/03/04/05/06/07/08/09.
Email id: inscoun@cioins.co.in website: www.cioins.co.in
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If you have a grievance, approach the grievance cell of Insurance Company first.
If complaint is not resolved/ not satisfied/not responded for 30 days then
You can approach The Office of the Insurance Ombudsman (Bimalokpal)
Please visit our website for details to lodge complaint with Ombudsman.

Office Details	Jurisdiction of Office Union Territory, District	Office Details	Jurisdiction of Office Union Territory, District
Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, **Ahmedabad – 380 001.** Tel.: 079 - 25501201/02/05/06 Email:bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu	Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, **Bhopal – 462 003.** Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email:bimalokpal.bhopal@cioins.co.in	Madhya Pradesh Chattisgarh
Office of the Insurance Ombudsman, 62, Forest park, **Bhubneshwar – 751 009.** Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email:bimalokpal.bhubaneswar@cioins.co.in	Orissa	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, **Chandigarh – 160 017.** Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email:bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana, (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh
Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, **CHENNAI – 600 018.** Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email:bimalokpal.chennai@cioins.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, **NEW DELHI – 110 002.New Delhi – 110 002.** Tel.: 011 - 23232481 / 23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, **Lucknow - 226 001.** Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti,	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, **Hyderabad - 500 004.** Tel.: 040 - 23312122 Fax: 040 - 23376599 Email:bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of UnionTerritory of Pondicherry

	Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.		
Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, **Guwahati – 781001(ASSAM).** Tel.: 0361 - 2132204 / 2132205 Email:bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), **Mumbai - 400 054.** Tel.: 69038821/23/24/25/26/27/28/28/29/30/31 Fax: 022 - 26106052 Email:bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, **Jaipur - 302 005.** Tel.: 0141 - 2740363 Email:bimalokpal.jaipur@cioins.co.in	Rajasthan	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, **Pune – 411 030.** Tel.: 020-41312555 Email:bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region
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	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.
Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, **Patna 800 006.** Tel.: 0612-2680952 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand	Office of the Insurance Ombudsman, 2nd Floor, Pulinat Building Opp. Cochin Shipyard, M.G Road, **Ernakulam – 682015** Tel: 0484-2358759/2359338 Fax: 0484-2359336 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe- A part of Union Territory of Pondicherry
Office of Insurance Ombudsman, 4th Floor, Hindusthan Building Annexe, 4, C.R. Avenure, Kolkatta – 700072 Tel:033-22124339/22124340 Fax: 033-22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim and Andeman & Nicobar Islands		

Annexure A

Section 38 - Assignment and Transfer of Insurance Policies

Assignment or transfer of a policy should be in accordance with Section 38 of the Insurance Act, 1938 as amended by Insurance Laws (Amendment) Act, 2015. The extant provisions in this regard are as follows:

1. This policy may be transferred/assigned, wholly or in part, with or without consideration.
2. An Assignment may be effected in a policy by an endorsement upon the policy itself or by a separate instrument under notice to the Insurer.
3. The instrument of assignment should indicate the fact of transfer or assignment and the reasons for the assignment or transfer, antecedents of the assignee and terms on which assignment is made.
4. The assignment must be signed by the transferor or assignor or duly authorized agent and attested by at least one witness.
5. The transfer of assignment shall not be operative as against an insurer until a notice in writing of the transfer or assignment and either the said endorsement or instrument itself or copy there of certified to be correct by both transferor and transferee or their duly authorized agents have been delivered to the insurer.
6. Fee to be paid for assignment or transfer can be specified by the Authority through Regulations.
7. On receipt of notice with fee, the insurer should Grant a written acknowledgement of receipt of notice. Such notice shall be conclusive evidence against the insurer of duly receiving the notice.
8. If the insurer maintains one or more places of business, such notices shall be delivered only at the place where the policy is being serviced.
9. The insurer may accept or decline to act upon any transfer or assignment or endorsement, if it has sufficient reasons to believe that it is-
   a. not bonafide or
   b. not in the interest of the policyholder or
   c. not in public interest or
   d. is for the purpose of trading of the insurance policy.
10. Before refusing to act upon endorsement, the Insurer should record the reasons in writing and communicate the same in writing to Policyholder within 30 days from the date of policyholder giving a notice of transfer or assignment.
11. In case of refusal to act upon the endorsement by the Insurer, any person aggrieved by the refusal may prefer a claim to IRDAI within 30 days of receipt of the refusal letter from the Insurer.
12. The priority of claims of persons interested in an insurance policy would depend on the date on which the notices of assignment or transfer is delivered to the insurer; where there are more than one instruments of transfer or assignment, the priority will depend on dates of delivery of such notices. Any dispute in this regard as to priority should be referred to Authority.
13. Every assignment or transfer shall be deemed to be absolute assignment or transfer and the assignee or transferee shall be deemed to be absolute assignee or transferee, except
    a. where assignment or transfer is subject to terms and conditions of transfer or assignment OR
    b. where the transfer or assignment is made upon condition that
       i) the proceeds under the policy shall become payable to policyholder or nominee(s) in the event of assignee or transferee dying before the insured OR
       ii) the insured surviving the term of the policy
       Such conditional assignee will not be entitled to obtain a loan on policy or surrender the policy. This provision will prevail notwithstanding any law or custom having force of law which is contrary to the above position.
14. In other cases, the insurer shall, subject to terms and conditions of assignment, recognize the transferee or assignee named in the notice as the absolute transferee or assignee and such person
    a. shall be subject to all liabilities and equities to which the transferor or assignor was subject to at the date of transfer or assignment and
    b. may institute any proceedings in relation to the policy
    c. obtain loan under the policy or surrender the policy without obtaining the consent of the transferor or assignor or making him a party to the proceedings
15. Any rights and remedies of an assignee or transferee of a life insurance policy under an Assignment or transfer effected before commencement of the Insurance Laws (Amendment) Act, 2015 shall not be affected by this section.

[Disclaimer: This is not a comprehensive list of amendments of Insurance Laws (Amendment) Act and only a simplified version prepared for general information. Policy Holders are advised to refer to the Insurance Act as amended from time.]

Annexure B

Section 39 - Nomination by policyholder

Nomination of a life insurance Policy is as below in accordance with Section 39 of the Insurance Act, 1938 as amended by Insurance Laws (Amendment) Act, 2015. The extant provisions in this regard are as follows:

1. The policyholder of a life insurance on his own life may nominate a person or persons to whom money secured by the policy shall be paid in the event of his death.
2. Where the nominee is a minor, the policyholder may appoint any person to receive the money secured by the policy in the event of policyholder's death during the minority of the nominee. The manner of appointment to be laid down by the insurer.
3. Nomination can be made at any time before the maturity of the policy.
4. Nomination may be incorporated in the text of the policy itself or may be endorsed on the policy communicated to the insurer and can be registered by the insurer in the records relating to the policy.
5. Nomination can be cancelled or changed at any time before policy matures, by an endorsement or a further endorsement or a will as the case may be.
6. A notice in writing of Change or Cancellation of nomination must be delivered to the insurer for the insurer to be liable to such nominee. Otherwise, insurer will not be liable if a bonafide payment is made to the person named in the text of the policy or in the registered records of the insurer.
7. Fee to be paid to the insurer for registering change or cancellation of a nomination can be specified by the Authority through Regulations.
8. On receipt of notice with fee, the insurer should grant a written acknowledgement to the policyholder of having registered a nomination or cancellation or change thereof.
9. A transfer or assignment made in accordance with Section 38 shall automatically cancel the nomination except in case of assignment to the insurer or other transferee or assignee for purpose of loan or against security or its reassignment after repayment. In such case, the nomination will not get cancelled to the extent of insurer's or transferee's or assignee's interest in the policy. The nomination will get revived on repayment of the loan.
10. The right of any creditor to be paid out of the proceeds of any policy of life insurance shall not be affected by the nomination.
11. In case of nomination by policyholder whose life is insured, if the nominees die before the policyholder, the proceeds are payable to policyholder or his heirs or legal representatives or holder of succession certificate.
12. In case nominee(s) survive the person whose life is insured, the amount secured by the policy shall be paid to such survivor(s).
13. Where the policyholder whose life is insured nominates his
    a. parents or
    b. spouse or
    c. children or
    d. spouse and children
    e. or any of them

    the nominees are beneficially entitled to the amount payable by the insurer to the policyholder unless it is proved that policyholder could not have conferred such beneficial title on the nominee having regard to the nature of his title.
14. If nominee(s) die after the policyholder but before his share of the amount secured under the policy is paid, the share of the expired nominee(s) shall be payable to the heirs or legal representative of the nominee or holder of succession certificate of such nominee(s).
15. The provisions of sub-section 7 and 8 (13 and 14 above) shall apply to all life insurance policies maturing for payment after the commencement of Insurance Laws (Amendment) Act 2015.
16. If policyholder dies after maturity but the proceeds and benefit of the policy has not been paid to him because of his death, his nominee(s) shall be entitled to the proceeds and benefit of the policy.
17. The provisions of Section 39 are not applicable to any life insurance policy to which Section 6 of Married Women's Property Act, 1874 applies or has at any time applied except where before or after Insurance Laws (Amendment) Act dated 2015, a nomination is made in favour of spouse or children or spouse and children whether or not on the face of the policy it is mentioned that it is made under Section 39. Where nomination is intended to be made to spouse or children or spouse and children under Section 6 of MWP Act, it should be specifically mentioned on the policy. In such a case only, the provisions of Section 39 will not apply.

[Disclaimer: This is not a comprehensive list of amendments of Insurance Laws (Amendment) Act, 2015 *and only a simplified version prepared for general information. Policy Holders are advised to refer to Act, 1938 as amended from time to time for complete and accurate details.]*

Annexure C

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

Provisions regarding policy not being called into question in terms of Section 45 of the Insurance Act, 1938, as amended by Insurance Laws (Amendment) Act, 2015 are as follows:

1. No Policy of Life Insurance shall be called in question **on any ground whatsoever** after expiry of 3 yrs from
   a. the date of issuance of policy or
   b. the date of commencement of risk or
   c. the date of revival of policy or
   d. the date of rider to the policy

   whichever is later.

2. On the ground of fraud, a policy of Life Insurance may be called in question within 3 years from
   a. the date of issuance of policy or
   b. the date of commencement of risk or
   c. the date of revival of policy or
   d. the date of rider to the policy

   whichever is later.

   For this, the insurer should communicate in writing to the insured or legal representative or nominee or assignees of insured, as applicable, mentioning the ground and materials on which such decision is based.

3. Fraud means any of the following acts committed by insured or by his agent, with the intent to deceive the insurer or to induce the insurer to issue a life insurance policy:
   a. The suggestion, as a fact of that which is not true and which the insured does not believe to be true;
   b. The active concealment of a fact by the insured having knowledge or belief of the fact;
   c. Any other act fitted to deceive; and
   d. Any such act or omission as the law specifically declares to be fraudulent.

4. Mere silence is not fraud unless, depending on circumstances of the case, it is the duty of the insured or his agent keeping silence to speak or silence is in itself equivalent to speak

5. No Insurer shall repudiate a life insurance Policy on the ground of Fraud, if the Insured /beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries.

6. Life insurance Policy can be called in question within 3 years on the ground that any statement of or suppression of a fact material to expectancy of life of the insured was incorrectly made in the proposal or other document basis which policy was issued or revived or rider issued. For this, the insurer should communicate in writing to the insured or legal representative or nominee or assignees of insured, as applicable, mentioning the ground and materials on which decision to repudiate the policy of life insurance is based.

7. In case repudiation is on ground of mis-statement and not on fraud, the premium collected on policy till the date of repudiation shall be paid to the insured or legal representative or nominee or assignees of insured, within a period of 90 days from the date of repudiation.

8. Fact shall not be considered material unless it has a direct bearing on the risk undertaken by the insurer. The onus is on insurer to show that if the insurer had been aware of the said fact, no life insurance policy would have been issued to the insured.

9. The insurer can call for proof of age at any time if he is entitled to do so and no policy shall be deemed to be called in question merely because the terms of the policy are adjusted on subsequent proof of age of life insured. So, this Section will not be applicable for questioning age or adjustment based on proof of age submitted subsequently.

[Disclaimer: This is not a comprehensive list of amendments of Insurance Laws (Amendment) Act, 2015 and only a simplified version prepared for general information. Policy Holders are advised to refer to Act, 1938 as amended from time to time for complete and accurate details.]