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: An accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.

Application Form means the application form and any other information / document provided by the Policyholder to the Company before the inception of this Policy.

Appointee means the person named by the Policyholder to receive payment, under this Policy if the Nominee is a minor at the time payment becomes due.

Base Sum Insured means the amount specified in the Schedule payable according to the terms and conditions of this Policy.

Congenital Anomaly means a condition which is present since birth, and which is abnormal with reference to form, structure or position.

a. Internal Congenital Anomaly means Congenital anomaly which is not in the visible and accessible parts of the body.
b. External Congenital Anomaly means Congenital anomaly which is in the visible and accessible parts of the body

Claimant shall mean the Life Insured (or) the Policyholder (or) the Nominee where a valid nomination has been effected or the Legal Heirs of the Policyholder/Nominee as the case may be.

Diagnosis or Diagnosed means the definitive diagnosis made by a Medical Practitioner during the Policy Term, based upon radiological, clinical, histological or laboratory evidence.

Grace Period means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases.

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) of the said Act OR complies with all minimum criteria as under:

i) Has qualified nursing staff under its employment round the clock;
ii) Has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
iii) Has qualified medical practitioner(s) in charge round the clock;
iv) Has a fully equipped operation theatre of its own where surgical procedures are carried out;
v) Maintains daily records of patients and makes these accessible to the insurer's authorized personnel.

Indexed Sum Insured is Base Sum Insured increased by 10% per annum (simple) starting first policy anniversary, for each completed 'claim free year'. Indexation would only be applicable till the date of diagnosis of critical illness or till Indexed Sum Insured reaches 150% of Base Sum Insured.

IRDAI means the Insurance Regulatory and Development Authority of India.

Illness

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.

Lapse means when all benefits under the Policy cease due to non-payment of Premium on due date or within the Grace Period.

Life Insured means the person(s) on whose life this Policy is/are effected and is/are named in the Schedule.

Maturity Date means the Policy Expiry Date specified in the Schedule and when the coverage under the Policy ends.

Medical Advice - Any consultation or advice from a Medical Practitioner including the issue 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 license but excluding the Physician who is :

- Insured/Policyholder himself or an agent of the Insured
- Insurance Agent , business partner(s) or employer/employee of the Insured or
- a member of the Insured's immediate family

Medically Necessary Treatment Medically necessary treatment means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:
i) is required for the medical management of the illness or injury suffered by the insured;
ii) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
iii) must have been prescribed by a medical practitioner;
iv) must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

Notification Of Claim: 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 by the Policyholder to receive payment, according to the terms and conditions of this Policy.

Pre-existing Disease: Pre-Existing Disease means any condition, ailment or injury or related condition(s) for which there were signs or symptoms, and / or were diagnosed, and / or for which medical advice / treatment was received within 48 months prior to the first policy issued by the insurer and renewed continuously thereafter.

Policy means this contract of insurance as evidence by the Policy Document.

Policy Anniversary means the anniversary of the Risk Commencement Date.

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

Policy Document means the Terms & Conditions, the Application Form and the Schedule as amended from time to time.

Policy Term means the period between the Risk Commence Date and Policy Expiry Date.

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

Policyholder means the person named in the Schedule who has concluded this Policy with the Company. Policyholder is the owner of the Policy.

Premium means the amount of premium payable by the Policyholder. The Schedule details the amount payable (**Policy Installment Premium**), when it is to be paid (**Premium Frequency**) and the term over which it is to be paid (**Premium Paying Period**).

Renewal means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

Revival means restoration of the Policy by the Company, which was discontinued due to the non-payment of Premium, with all the benefits mentioned in the Policy Document, as per the terms and conditions of the Policy.

Risk Commencement Date means the date as specified in the Schedule from which the risk cover starts under this Policy.

Schedule means the document attached to this Policy which provides a snapshot of the Policy and benefits 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.

Surgery or Surgical Procedure: 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 of suffering or prolongation of life, performed in a hospital or day care centre by a medical practitioner.

Definitions – pertaining to Cancer

Minor Cancer:

Early Stage Cancer:

Early Stage Cancer shall mean first ever diagnosis with the presence of one of the following malignant conditions:
I. Tumour of the thyroid histologically classified as T1N0M0 according to the TNM classification;
II. Prostate tumour should be histologically described as TNM Classification T1a or T1b or T1c are of another equivalent or lesser classification.
III. Chronic lymphocytic leukaemia classified as RAI Stage I or II;
IV. Basal cell and Squamous skin cancer that has spread to distant organs beyond the skin,
V. Hodgkin's lymphoma Stage I by the Cotswold's classification staging system.
VI. All tumours of the urinary bladder histologically classified as T1N0M0 (TNM Classification)

The Diagnosis must be based on histopathological features and confirmed by a Pathologist.

Pre-malignant lesions and conditions, unless listed above, are excluded.

Carcinoma-in-situ:

Carcinoma-in-situ shall mean first ever diagnosis of a histologically proven, localized pre-invasion lesion where cancer cells have not yet penetrated the basement membrane or invaded (in the sense of infiltrating and / or actively destroying) the surrounding tissues or stroma in any one of the following covered organ groups, and subject to any classification stated:
i. Breast, where the tumour is classified as Tis according to the TNM Staging method;
ii. Uterus, vagina, vulva or fallopian tubes where the tumour is classified as TIS according to the TNM Staging method or FIGO* Stage 0;
iii. Cervix uteri, classified as cervical intraepithelial neoplasia grade III (CIN III) or as Tis according the TNM Staging method or FIGO* Stage 0;
iv. Ovary –include borderline ovarian tumours with intact capsule, no tumour on the ovarian surface, classified as T1aN0M0, T1bN0M0 (TMN Staging) or FIGO 1A, FIGO 1B;
v. Colon and rectum;
vi. Penis;
vii. Testis;
viii. Lung;
ix. Stomach and esophagus;
x. Urinary tract, for the purpose of in-situ cancers of the bladder and uroepithelium, stage Ta of papillary carcinoma is included
xi. Nasopharynx

For purposes of this Policy, Carcinoma-in-situ must be confirmed by a biopsy & confirmed by a Registered Medical Practitioner.

* FIGO refers to the staging method of the Federation Internationale de Gynecologie etd'Obstetrique

Pre-malignant lesions and carcinoma in situ of any organ, unless listed above, are excluded.

Major Cancer:

Cancer Of Specified Severity:

i. 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 leukaemia, lymphoma and sarcoma.

ii. The following as excluded:
   i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.
   ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
   iii. Malignant melanoma that has not caused invasion beyond the epidermis
   iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0.
   v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below
   vi. Chronic lymphocytic leukaemia less than RAI stage 3
   vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
   viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
   ix. All tumors in the presence of HIV infection

Definitions – pertaining to Heart

Minor Heart Conditions:

Heart Conditions means illness/disease , where the insured had or is aware of objective evidence, had consultations/Investigations for it ,or was diagnosed with the disease which first became apparent or commenced more than 180 days following the Issue Date or Commencement Date or the date of any reinstatement of this Contract, whichever is the latest and shall include either the first diagnosis of any of the following illnesses or first performance of any of the covered surgeries stated below

Initial implantation of Permanent Pacemaker of Heart or Insertion of Implantable Cardioverter defibrillator (ICD): Actual undergoing of insertion of a permanent cardiac pacemaker or cardiac defibrillator to correct serious cardiac arrhythmia which cannot be treated via other methods or the insertion of permanent cardiac defibrillator to correct sudden loss of heart function with cessation of blood circulation around the body resulting in unconsciousness .

Insertion of Cardiac Defibrillator means surgical implantation of either Implantable Cardioverter- Defibrillator (ICD), or Cardiac Resynchronization Therapy with Defibrillator (CRT-D).

The insertion of a permanent Cardiac Pacemaker or Cardioverter-Defibrillator (ICD) must be certified to be absolutely necessary by a specialist in the relevant field.

Cardiac arrest secondary to alcohol or drug misuse will be excluded.

Angioplasty And Stenting Of Coronary Arteries:

1. Coronary Angioplasty is defined as percutaneous coronary intervention by way of balloon angioplasty with or without stenting for the treatment of the narrowing or blockage of minimum 50% of one or more major coronary arteries. The intervention must be determined to be medically necessary by a Cardiologist and supported by coronary angiogram (CAG).
2. Coronary arteries herein refer only to Left Main Stem, Left Anterior Descending, Circumflex and Right Coronary Artery.
3. Diagnostic Angiography or investigation procedures without angioplasty/stent insertion are excluded.

Angioplasty and Stenting for Carotid Arteries: Angioplasty and Stenting for Carotid Arteries shall mean the treatment of stenosis of 50% or above, as proven by angiographic evidence of one or more of carotid arteries. All of the following criteria must be met:
1. Actual undergoing of an endovascular intervention such as angioplasty and/or stenting or atherectomy to alleviate the symptoms; and
2. The Diagnosis and medical necessity of the treatment must be confirmed by a Registered Medical Practitioner who is a specialist in the relevant field.

Renal Angioplasty: Means the actual undergoing for the first time of Renal Artery Angioplasty or the insertion of a stent to correct the stenosis, of one or more renal arteries as shown by Angiographic or appropriate imaging evidence. The revascularization must be considered medically necessary by an appropriate specialist. Intra Arterial investigative procedures and Diagnostic Angiography are excluded.

Percutaneous Procedures for Heart Valve Repair or Replacement: Percutaneous valve surgery refers to percutaneous valvuloplasty, percutaneous valvotomy and percutaneous valve replacement where the procedure is performed totally via intravascular catheter based techniques.

The diagnosis of heart valve abnormality must be supported by cardiac catheterization or Echocardiogram and the procedure must be considered medically necessary by a consultant cardiologist

Surgical Septal Myomectomy to relieve Left ventricular Outflow Tract (LVOT) obstruction In Hypertrophic Obstructive Cardiomyopathy: Actual undergoing of a surgical procedure to relive LVOT obstruction in HOCM by direct removal of cardiac septal muscle. The LVOT obstruction should be causing:
a. Significant heart failure (NYHA CLASS III/IV) despite maximal medical therapy
b. LVOT gradient >/=50 mmhg at rest
c. recurrent syncope judged to be related to LVOT obstruction
Procedure should be considered medically necessary by a cardiologist.

Pericardectomy: The undergoing of a Pericardectomy through a median sternotomy or a thoracotomy approach for the treatment of constrictive pericarditis or recurrent pericarditis. The surgical procedure must be certified to be absolutely necessary by a Specialist in cardiology.

Definitions – pertaining to Heart

Major Heart Conditions:

Myocardial Infarction (First Heart Attack – Of Specified 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 of Myocardial Infarction should be evidenced by all of the following criteria:
a) a history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)
b) new characteristic electrocardiogram changes
c) elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:
a. Other acute Coronary Syndromes
b. Any type of angina pectoris.
c. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

Cardiomyopathy: An impaired function of the heart muscle, unequivocally diagnosed as Cardiomyopathy by a Registered Medical Practitioner who is a cardiologist, and which results in permanent physical impairment to the degree of New York Heart Association classification Class IV or its equivalent, for at least six (6) months based on the following classification criteria:
Class IV - Inability to carry out any activity with-out discomfort. Symptoms of congestive cardiac failure are present even at rest. With any in-crease in physical activity, discomfort will be experienced. The Diagnosis of Cardiomyopathy has to be supported by echographic findings of compromised ventricular performance.
Irrespective of the above, Cardiomyopathy directly related to alcohol or drug abuse is excluded.

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

a. Transient ischemic attacks (TIA)
b. Traumatic injury of the brain
c. Vascular disease affecting only the eye or optic nerve or vestibular functions.

Open Chest CABG:
The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s) , by coronary artery bypass grafting done via 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 is excluded:
Angioplasty and/or any other intra-arterial procedures

Major surgery of the Aorta: The actual undergoing of surgery for a disease or injury of the aorta needing excision and surgical replacement of the diseased part of the aorta with a graft.

The term “aorta” means the thoracic and abdominal aorta but not its branches. Surgery performed using only minimally invasive or intra-arterial techniques are excluded.

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

Heart Transplant: The actual undergoing of a transplant of the Heart, that resulted from irreversible end-stage failure of the organ.

The undergoing of a transplant has to be confirmed by a specialist medical practitioner.
Stem cell Transplants are excluded.

Primary (Idiopathic) Pulmonary Hypertension:
I. An unequivocal diagnosis of Primary (Idiopathic) pulmonary hypertension by a cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of HG on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

II. The NHYA Classification of Cardiac Impairment are as follows:
i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

III. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, disease of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

PRAMERICA LIFE CANCER+HEART SHIELD
(NON LINKED NON PARTICIPATING FIXED BENEFIT INDIVIDUAL HEALTH PRODUCT)

Definitions – pertaining to Major Illnesses

Major Illness Conditions:

Major CI Conditions means illness/disease, where the insured had or is aware of objective evidence, had consultations/Investigations for it ,or was diagnosed with the disease which first became apparent or commenced more than 180 days following the Issue Date or Commencement Date or the date of any reinstatement of this Contract, whichever is the latest and shall include either the first diagnosis of any of the following illnesses or first performance of any of the covered surgeries stated below:

Alzheimer's Disease: Progressive and permanent deterioration of memory and intellectual capacity as evidenced by accepted standardised questionnaires and cerebral imaging. The diagnosis of Alzheimer's disease must be confirmed by an appropriate consultant and supported by the Company's appointed doctor. There must be significant reduction in mental and social functioning requiring the continuous supervision of the Life Assured. There must also be an inability of the Life Assured to perform (whether aided or unaided) at least 3 of the following 6 "Activities of Daily Living" for a continuous period of at least 3 months:
Activities of Daily Living are defined as:
1. Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
2. Dressing – the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
3. Transferring – the ability to move from a bed to an upright chair or wheelchair and vice versa;
4. Toileting – the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
5. Feeding – the ability to feed oneself once food has been prepared and made available.
6. Mobility - the ability to move from room to room without requiring any physical assistance.

The following are excluded:
- Any other type of irreversible organic disorder/ dementia
- Non-organic disease such as neurosis and psychiatric illnesses; and
- Alcohol related brain damage

Aplastic Anaemia: Chronic Irreversible persistent bone marrow failure which results in Anaemia, Neutropenia and Thrombocytopenia requiring treatment with at least TWO of the following:
a. Regular blood product transfusion;
b. Marrow stimulating agents;
c. Immunosuppressive agents; or
d. Bone marrow transplantation.

The diagnosis and suggested line of treatment must be confirmed by a Haematologist acceptable to the Company using relevant laboratory investigations, including bone-marrow biopsy. Two out of the following three values should be present:
a. Absolute neutrophil count of 500 per cubic millimetre or less;
b. Absolute erythrocyte count of 20 000 per cubic millimetre or less; and
c. Platelet count of 20 000 per cubic millimetre or less.

Temporary or reversible aplastic anaemia is excluded.

Deafness: Total and irreversible loss of hearing in both ears as a result of illness or accident . The 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.

Loss of Speech: Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. The diagnosis must be supported by medical evidence furnished by an Ear, Nose, Throat (ENT) specialist.

All psychiatric related causes are excluded.

Medullary Cystic Kidney Disease: Medullary Cystic Disease where the following criteria are met:
a. the presence in the kidney of multiple cysts in the renal medulla accompanied by the presence of tubular atrophy and interstitial fibrosis;
b. clinical manifestations of anaemia, polyuria, and progressive deterioration in kidney function; and
c. the Diagnosis of Medullary Cystic Disease is confirmed by renal biopsy.

Isolated or benign kidney cysts are specifically excluded from this benefit.

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:
I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
a. investigations including typical MRI findings, which unequivocally confirm the diagnosis to be multiple sclerosis; and
b. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months,

II. Other causes of neurological damage such as SLE and HIV are excluded.

Parkinson's Disease: The unequivocal diagnosis of primary idiopathic Parkinson's disease (all other forms of Parkinsonism are excluded) made by a consultant neurologist. This diagnosis must be supported by all of the following conditions:

a. The disease cannot be controlled with medication; and
b. Objective signs of progressive impairment; and
c. There is an inability of the Life assured to perform (whether aided or unaided) at least 3 of the following five (6) "Activities of Daily Living" for a continuous period of at least 6 months.

The Activities of Daily Living are:
1. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
2. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
3. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
4. Mobility: the ability to move indoors from room to room on level surfaces;
5. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
6. Feeding: the ability to feed oneself once food has been prepared and made available

Drug-induced or toxic causes of Parkinsonism excluded

Systemic Lupus Erythematosus (SLE) with Lupus Nephritis: A multi-system, mutlifactorial, autoimmune disease characterized by the development of auto-antibodies directed against various selfantigens. In respect of this Contract, Systemic Lupus Erythematosus (SLE) will be restricted to those forms of systemic lupus erythematosus which involve the kidneys (Class III to Class V Lupus Nephritis, established by renal biopsy, and in accordance with the WHO Classification). The final diagnosis must be confirmed by a certified doctor specializing in Rheumatology and Immunology. There must be positive antinuclear antibody test.

Other forms, discoid lupus, and those forms with only haematological and joint involvement will be specifically excluded.

WHO Classification of Lupus Nephritis:
Class I: Minimal change Lupus Glomerulonephritis – Negative, normal urine.
Class II: Messangial Lupus Glomerulonephritis – Moderate Proteinuria, active sediment
Class III: Focal Segmental Proliferative Lupus Glomerulonephritis – Proteinuria, active sediment
Class IV: Diffuse Proliferative Lupus Glomerulo-nephritis – Acute nephritis with active sediment and / or nephritic syndrome.
Class V: Membranous Lupus Glomerulonephritis – Nephrotic Syndrome or severe proteinuria.

Apallic Syndrome: Universal necrosis of the brain cortex, with the brain stem remaining intact. Diagnosis must be definitely confirmed by a Registered Medical practitioner who is also a neurologist holding such an appointment at an approved hospital. This condition must be documented for at least one (1) month.

Benign Brain Tumor:

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

II. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.

i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
ii. Undergone surgical resection or radiation therapy to treat the brain tumor

III. The following conditions are excluded:
a. Cysts
b. Granulomas
c. Malformations in the arteries and veins of the brain,
d. Hematomas;
e. Abscesses
f. pituitary tumors,
g. Tumors of skull bones and tumors of spinal cord;

Blindness:
a) Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident.
b) The Blindness is evidenced by :
i. corrected visual acuity being 3/60 or less in both eyes or ;
ii. the field of vision being less than 10 degrees in both eyes.

c) The diagnosis of blindness must be confirmed and must not be correctable by aides or surgical procedures.

Brain Surgery: The actual undergoing of surgery to the brain under general anaesthesia during which a craniotomy with removal of bone flap to access the brain is performed. The following are excluded:
a. Burr hole procedures, transphenoidal procedures and other minimally invasive procedures such as irradiation by gamma knife or endovascular embolizations, thrombolysis and stereotactic biopsy
b. Brain surgery as a result of an accident

End-stage Lung Failure: End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:
a. FEV 1 test results consistently less than 1 litre measured on 3 occasions 3 months apart ; and

b. Requiring continuous permanent supplementary oxygen therapy for hypoxemia;
c. Arterial blood gas analyses with partial oxygen pressures of 55mmHg or less (PaO2 < 55mm Hg); and
d. Dyspnea at rest.

Coma of specified severity: A state of unconsciousness with no reaction or response to external stimuli or internal needs.

This diagnosis must be supported by evidence of all of the following:
a. no response to external stimuli continuously for at least 96 hours;
b. life support measures are necessary to sustain life; and
c. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

End stage liver Failure: Permanent and irreversible failure of liver function that has resulted in all three of the following:
a. Permanent jaundice
b. Ascites ;and
c. Hepatic encephalopathy.

Liver failure secondary to alcohol or drug abuse is **excluded**.

Kidney Failure requiring regular dialysis: End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (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: 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.

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.

Major Head Trauma:

I. Accidental head injury resulting in permanent neurological deficit to be assessed no sooner than 3 months from the date of the Accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The Accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.

II. The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids or adaptations in use for disabled persons. For the purpose of this benefit, the word "permanent" shall mean beyond the scope of recovery with current medical knowledge and technology.

III. The Activities of Daily Living are:
1. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
2. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
3. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
4. Mobility: the ability to move indoors from room to room on level surfaces;
5. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
6. Feeding: the ability to feed oneself once food has been prepared and made available.

IV. The following are excluded:
(a) Spinal cord injury;

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.

Fulminant Viral Hepatitis: A submassive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure. This diagnosis must be supported by all of the following:
• rapid decreasing of liver size as confirmed by abdominal ultrasound; and
• necrosis involving entire lobules, leaving only a collapsed reticular framework(histological evidence is required); and
• rapid deterioration of liver function tests; and
• deepening jaundice; and
• hepatic encephalopathy.

Hepatitis B infection carrier alone does not meet the diagnostic criteria.

This excludes Fulminant Viral Hepatitis caused by alcohol, toxic substance or drug.

Muscular Dystrophy: A group of hereditary degenerative diseases of muscle characterized by weakness and atrophy of muscle based on three (3) out of four (4) of the following conditions:

(a) Family history of other affected individuals;
(b) Clinical presentation including absence of sensory disturbance, normal cerebrospinal fluid and mild tendon reflex reduction;
(c) Characteristic electromyogram; or
(d) Clinical suspicion confirmed by muscle biopsy.
The diagnosis of muscular dystrophy must be unequivocal and made by a consultant neurologist**.**

The condition must result in the inability of the Life Assured to perform (whether aided or unaided) at least three (3) of the six (6) 'Activities of Daily Living' as defined, for a continuous period of at least six (6) months.

Activities of Daily Living are defined as:
1. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
2. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
3. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
4. Mobility: the ability to move indoors from room to room on level surfaces;
5. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
6. Feeding: the ability to feed oneself once food has been prepared and made available

Poliomyelitis: The occurrence of Poliomyelitis where the following conditions are met:
1. Poliovirus is identified as the cause and is proved by Stool Analysis,
2. Paralysis of the limb muscles or respiratory muscles must be present and persist for at least 3 months.

The diagnosis of Poliomyelitis must be confirmed by a Registered Medical Practitioner who is a Neurologist

Loss of Independent Existence: Confirmation by a Consultant Physician of the loss of independent existence due to illness or trauma, lasting for a minimum period of 6 months and resulting in permanent inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word "permanent", shall mean beyond the scope of recovery with current medical knowledge and technology

Activities of Daily Living are defined as:
1. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
2. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
3. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
4. Mobility: the ability to move indoors from room to room on level surfaces;
5. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
6. Feeding: the ability to feed oneself once food has been prepared and made available

Pneumonectomy: The undergoing of surgery on the advice of a consultant medical specialist to remove an entire lung for any physical injury or disease

PRAMERICA LIFE CANCER+HEART SHIELD
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PART C
Specific Terms and Conditions

Section One: Policy Benefits

The Benefit under the Policy shall be payable on diagnosis/ procedures of the condition (as defined in Part B), depending upon the Coverage Type, Benefit Payout option, stage and severity of conditions/illness.

Benefit option: Care
Minor Stage:
i. 25% of Base Sum Insured paid immediately.
ii. Monthly income payable every month for next 6 months starting from the date of payment of Minor claim, first payment made immediately with lump sum benefit.

Major Stage:
i. 100% of Base Sum Insured less amount already paid as Minor Stage claim (25% of Base Sum Insured), if any paid immediately first payment made immediately with lump sum benefit.

Benefit Option: Care+
Minor Stage:
i. 25% of Indexed Sum Insured paid immediately.
ii. Monthly income payable every month for next 6 months starting from the date of payment of Minor claim, first payment made immediately with lump sum benefit..

Major Stage:
i. 100% of Indexed Sum Insured less amount already paid as Minor Stage claim (25% of Indexed Sum Insured), if any paid immediately.
ii. Monthly Income payable every month for next 5 years starting from the date of payment of Major claim first payment made immediately with lump sum benefit.

On diagnosis of critical illness under the policy for all benefit options, Premium for next 3 Years will be waived off from the next premium due date following the date of diagnosis of critical illness. In case outstanding term is less than three years then premiums for the outstanding term would be waived. This benefit is available only once during the lifetime of the Policy

In case the outstanding term is more than three years then the Premium will be waived only for a period of three years. The Policyholder will need to resume payment of Premiums thereafter without paying any arrears for the last three years.

In case a claim is made under both of the minor and major categories for Care+ benefit option, then the Monthly Income benefit will be paid under each of the category and can continue to be paid together. In such case Monthly Income under minor will continue to be paid for 6 months, along with the Monthly income payable in case of claim under Major category for 5 Policy years payable monthly.

In case of death of Life Insured while monthly income is being paid, the payouts will continue for defined duration and amount will be paid to Nominee or Legal Heirs of Life Assured.

No. of Claims payable as per Coverage Option:

Option I: Cancer Shield: One Minor & one Major claim will become payable during entire Policy Term
Option II: Heart Shield: One Minor & one Major claim will become payable during entire Policy Term
Option III: Cancer & Heart Shield: Two minor (one each from Cancer and Heart) and two major claims (one each from Cancer and Heart) will become payable during entire Policy Term.
Option IV: Comprehensive Shield: Two minor (one each from Cancer and Heart) and three major claims (one each from Cancer, Heart and Major CI each) will become payable during entire Policy Term

In case of Option III & Option IV; after paying claim for one major condition, Policy will continue for remaining conditions as stated at inception of the Policy.

All these benefits are payable only if the policy is in-force and is not a lapsed policy.

In case Policyholder chooses Option I or Option II, waiver of Premium will be applicable only on occurrence of minor stage claim. The coverage will immediately terminate on payment of major stage benefit and no Waiver of Premium would be applicable.

Under Option III and Option IV, the waiver of Premium is applicable on first claim (minor/major). The Policy will continue for the remaining benefits thereafter

No Maturity Benefit shall be payable under this policy.

Section Two: Discontinuation of Premium Payments

a) If the Premium has not been received in full by its due date or within the Grace Period, the Policy shall automatically lapse at the end of the Grace Period.

b) A lapsed Policy can be revived as per the Terms and Conditions of this Policy.

Section Three: **Payment of Premium**

The Premium must be paid as and when due. If the corresponding date does not exist in a particular month, then the last day of that calendar month shall be deemed to be the due date for payment.

Policy Installment Premium shall be deemed to have been paid only when received and realized by the Company.

Section Four: Waiting Period

A waiting period of 180 days will apply from the date of commencement/revival of the cover, whichever is later. The Company will not entertain any claim arising due to any illness/ disease, where the insured had or is aware of objective evidence, had consultations/Investigations for it, or was diagnosed with the disease which first became apparent or commenced within the waiting period under this policy.

Section Five: Survival Period

A survival period of 7 days from the date of diagnosis of cancer. This means that the insured has to survive 7 days after the "full histopathological diagnosis" of the cancer, including stage and grading. Failure to do so entitles the Insurance Company to refuse any claim under this cover.

A survival period of 7 days from the date of diagnosis of cardiovascular related conditions/procedures would be applicable. For conditions defined under other major CI, there would be a 15 days survival period applicable from date of diagnosis of the condition to date of eligibility for the benefit payment. There will be no claim admissible during survival period

Section Six: Premium Guarantee

For any policy sold, the rates shall be guaranteed for the first 3 Policy years from the commencement of this policy and reviewable thereafter on prior approval from the IRDAI. Any change in rates will apply both to new business (sold on or after the effective date of the change) and to existing business (from the later of the 3rd policy anniversary or the policy anniversary on or immediately following the effective date of the change). The revised premium rates shall be notified to the Policyholder at least 3 months prior to the date of such revision and policy holder will be given a period of 30 days from the date of premium due (on or after the effective date of change) to renew the policy. If the Policyholder is not willing to continue the Policy with the revised Premium rates, the Policy will lapse.

Premium rates, if and when revised, shall be guaranteed to the Policyholder for a subsequent block of three Policy years.

Section Seven: Exclusions

General Exclusions for Cancer:

A waiting period of 180 days will apply from the date of commencement/revival of the cover, whichever is later. The Company will not entertain any claim arising due to any illness/disease, where the insured had or is aware of objective evidence, had consultations/Investigations for it, or was diagnosed with the disease which first became apparent or commenced within the waiting period under this policy.

No benefit shall be payable under the policy in respect of any Major Cancer, Carcinoma-in-situ or Early Stage Cancer resulting directly or indirectly from or caused or contributed by (in whole or in part) :

a. Sexually Transmitted Diseases AIDS or HIV.
b. Any illness due to a congenital defect or disease which has manifested or was diagnosed before the Insured attains age 18. If congenital disorder is observed at the inception, the cover will not be provided. Otherwise, once congenital disorder is disclosed at proposal stage and accepted, claims will be processed as per policy Terms and conditions; or
c. Any pre-existing condition (as defined above). No benefits will be payable for any condition(s) which is a direct or indirect result of any pre-existing conditions unless Life Assured has disclosed the same at the time of proposal or date of revival whichever is later and the Company has accepted the same
d. Intoxication by alcohol or narcotics or drugs not prescribed by a Registered Medical Practitioner.
e. Nuclear, biological or chemical contamination (NBC) Ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from burning nuclear fuel; the radioactive, toxic, explosive or other dangerous properties of any explosive nuclear equipment or any part of that equipment; or biological or chemical contamination.

In addition, no benefit will be payable:

a. Deliberate failure to seek medical advice or intentional delay of medical treatment in order to circumvent the waiting period or other conditions and restriction applying to this policy.
b. For treatment like Ayurvedic, Homeopathy, Unani, naturopathy, reflexology, acupuncture, bone-setting, herbalist treatment, hypnotism, rolfing, massage therapy, aroma therapy or any other treatments other than Allopathy / western medicines.
c. No benefits shall be payable under this Policy for Cancer, Carcinoma in situ and Early Stage Cancer diagnosed or with the illness, where the insured had or is aware of objective evidence, had consultations/Investigations for it ,or was diagnosed with the disease which first became apparent or commenced within 180 Days following the effective date of the commencement of the policy or reinstatement (whichever is later).
d. No benefit is payable under this Policy for Cancer, Carcinoma-in-situ and Early Stage Cancer if the Insured Person has survived for less than seven (7) days following the diagnosis of Cancer, Carcinoma-in-situ and Early Stage Cancer

General Exclusions for Heart and other Major Illnesses:

Apart from the disease specific exclusions, no benefit will be payable if any of the cardiovascular condition is caused or aggravated directly or indirectly by any of the following:

a. Any medical condition which first manifests itself within 180 days of the risk commencement date or reinstatement date whichever is later.
b. Any Pre-existing illness (as defined above) or physical condition. No benefits will be payable for any condition(s) which is a direct or indirect result of any pre-existing conditions unless Life Assured has disclosed the same at the time of proposal or date of revival whichever is later and the Company has accepted the same.
c. Any illness due to a congenital defect or disease which has manifested or was diagnosed before the Insured attains age 18. If congenital disorder is observed at the inception, the cover will not be provided. Otherwise, once congenital disorder is disclosed at proposal stage and accepted, claims will be processed as per policy terms and conditions; or related illness
d. Suicide or attempted suicide or intentional self-inflicted injury, by the life insured, whether sane or not at that time.
e. Life assured being under the influence of drugs, alcohol, narcotics or psychotropic substance, not prescribed by a Registered Medical Practitioner

f. War, invasion, hostilities (whether war is declared or not), civil war, rebellion, terrorist activity, revolution or taking part in a riot or civil commotion, strikes or industrial action.
g. Participation by the life assured in a criminal or unlawful act with criminal intent or committing any breach of law including involvement in any fight or affray.
h. Treatment for injury or illness caused by avocations / activities such as hunting, mountaineering, steeple-chasing, professional sports, racing of any kind, scuba diving, aerial sports, activities such as hand-gliding, ballooning, deliberate exposure to exceptional danger.
i. Any underwater or subterranean operation or activity. Racing of any kind other than on foot.
j. Existence of any sexually Transmitted Disease (STD) and its related complications or Acquired Immune Deficiency Syndrome (AIDS) or the presence of any Human Immunodeficiency Virus (HIV).
k. Participation by the insured person in any flying activity other than as a bona fide fare paying passenger, in a licensed aircraft.
l. Deliberate failure to seek medical advice or intentional delay of medical treatment in order to circumvent the waiting period or other conditions and restriction applying to this policy.
m. Nuclear reaction, Biological, radioactive or chemical contamination due to nuclear accident.
n. Ayurvedic, Homeopathy, Unani, herbalist treatment, any other treatments other than Allopathy / western medicines.

PART D
Policy Servicing

Section One: Revival

Revival of a lapsed policy is available up to 2 years from the date of first unpaid premium. The revival of the policy shall be subject to the Board approved underwriting policy, as applicable from time to time. The Company reserves the right to obtain additional information before reviving the Policy and also has the right to decline revival of the Policy or impose extra mortality ratings as per the board approved underwriting policy of the Company. The medical expenses, if any, shall be borne by the Policyholder.

The policyholder would be required to pay all outstanding premiums due till the proposed date of revival together with any applicable interest. The unpaid premiums to be paid by the policyholder upon revival shall be based on the corresponding rates i.e. original premium amount for the period when original premium rates were applicable and revised premium amount for the period from the date of revision of premium rates till the date of revival. The rate of interest shall be reset on an annual basis at the beginning of every financial year (April) and would be determined based on the average of 10-year G-Sec YTM plus 75 bps rounded down to 25 bps. The average of the benchmark would be taken from the previous financial year for the period 1st July xxxx to 31st Dec xxxx. The source of information for 10 year GSec rate would be “Bloomberg”.

The current applicable rate of interest on policy reinstatement is 8.25% per annum which would be applicable for the FY 2016-17.

Section Two: Surrender of Policy

No Surrender Value shall be payable under this policy.

Section Three: Loan

No loan can be availed under this Policy.

Section Four: Free Look Period

The Policyholder shall have a period of 15 days (30 days in case of the policy sold through distance marketing mode) from the receipt of this Policy Document to review the terms and conditions of this Policy and if the Policyholder disagrees with any of the terms and conditions, Policyholder has the option to return this Policy stating the reasons for the objections upon which the Company shall refund to the Policyholder the Premium paid subject to deduction of proportionate Risk Premium for the period of risk cover, any expenses incurred by the Company towards medical examination of the Life Insured and stamp duty charges.

Part E
Charges - Not Applicable

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Part F

General Terms and Conditions

Section One: Benefit during Grace Period

If the Life Insured is diagnosed of specified conditions/illnesses during the Grace Period, the Company will pay the benefit payable after deduction of the Premium due under the Policy.

Section Two: Termination of the Policy

This Policy shall immediately and automatically terminate on the occurrence of the first of the following events and the applicable amount, if any have been paid in accordance with the terms and conditions of this Policy:

a) The date on which policy completes its tenure
b) The date of the death of the Life Insured
c) The date on which all the defined benefits are paid

Section Three: Claim Processing

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

a) is immediately notified in writing, and preferably within 30 days of the diagnosis of the defined illnesses/conditions, as applicable. 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) is provided with the opportunity of establishing to its satisfaction that a claim is payable.

c) receives all reasonable cooperation and is entitled to seek any documentation and information, including but not limited to:

(1) The Company's claim form duly completed.
(2) Copy of Policy Document.
(3) Claimant's bank details with proof, identity and residence proof.
(4) Claimant statement
(5) Attending physician's statement
(6) Attested True Copy of Indoor Case papers of the Hospital(s)
(7) Discharge summary of present and past Hosplitalizations
(8) First consultation and Follow-up consultation notes
(9) Diagnosis certificate from specialist
(10) Authorization/Consent Letter to collect medical records from Hospital
(11) Employer certificate, if employed
(12) All medical examination reports, incl
  (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
  Attested Certificate by Medical Specialist with exact diagnosis alongwith staging and grading and the treatment undergone for which claim is made.

The Company may on a case to case basis may call for additional documents that may be required any time during the process of claims assessment either for fulfillment of definition or to rule out any past medical condition as may be deemed necessary.

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 Four: Assignment

The provisions of Assignment are governed by Section 38 of Insurance Act, 1938 as amended from time to time.

A Leaflet containing the simplified version of the provisions of Section 38 of the Insurance Act 1938 is enclosed as Annexure A for reference.

Section Five: 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 Six: Miscellaneous

a) 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 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 Policyholder agrees to pay an amount not exceeding Rs. 250/- towards the Company's fee for the issue of a duplicate, and

2. The original Policy Document will cease to be of any legal effect and the 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.

b) 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 address as mentioned below.
ii) All notices meant for the Policyholder will be in writing and will be sent by the Company to the Policyholder's address shown in the Schedule or any such other address as may be communicated to the Company by the Policyholder.
iii) The Company shall not be responsible for any consequences related to or arising out of non intimation of changes to the Policyholder's address.

c) Misstatement of Age

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

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

d) Currency & Territorial Limits

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

e) 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.

f) Entire Contract & Agent's Authority

The Policy Document comprises the entire contract between the Policyholder and the Company, and it cannot be changed or altered unless the Company approves 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 Policyholder's Application Form. The insurance agent is not 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 Policyholder's risk and the agent will be acting only as the Policyholder's representative.

g) Taxes

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

h) Fraud and misrepresentation

Fraud, misrepresentation and forfeiture 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.

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PART G
Other Details

Grievance Redressal

I) In case of any clarification or query please contact your Company Salesperson.

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., (Erstwhile DHFL Pramerica Life Insurance Company 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., (Erstwhile DHFL Pramerica Life Insurance Company 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 or within 15 days timelines the Grievance Redressal Cell of the IRDAI may be contacted.

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

Complaints against Life Insurance Companies:
Insurance Regulatory and Development Authority of India
Consumer Affairs Department
Sy. No. 115/1, Financial District, Nanakramguda,
Gachibowli, Hyderabad – 500032

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.

In case you are not satisfied with the decision/resolution of the Company, you may approach the Insurance Ombudsman if your grievance pertains to:

I) Insurance claim that has been rejected or dispute of a claim on legal construction of the policy
II) Delay in settlement of claim
III) Dispute with regard to premium
IV) Non-receipt of your insurance document

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

Link
http://www.irda.gov.in/ADMINCMS/cms/NormalData_Layout.aspx?page=PageNo234&mid=7.2

The complaint should be made in writing duly signed by the complainant or by his legal heirs with full details of the complaint and the contact information of complainant.

As per provision 13(3) of the Redressal of Public Grievances Rules 1998, the complaint to the Ombudsman can be made only if the grievance has been rejected by the Grievance Redressal Machinery of the Insurer within a period of one year from the date of rejection by the insurer if it is not simultaneously under any litigation.

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Address & Contact Details of Ombudsmen

Office of The Governing Body of Insurance Council
(Monitoring Body for Offices of Insurance Ombudsman)
3rd Floor, Jeevan Seva Annexe, Santacruz(West), Mumbai – 400054. Tel no: 26106671/6889.
Email id: inscoun@gbic.co.in website: www.gbic.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@ecoi.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@ecoi.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@ecoi.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@ecoi.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, 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@ecoi.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.** Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@ecoi.co.in	Delhi.
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@ecoi.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.	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 - 65504123 / 23312122 Fax: 040 - 23376599 Email:bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry

Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, **Guwahati – 781001(ASSAM).** Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email:bimalokpal.guwahati@ecoi.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.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email:bimalokpal.mumbai@ecoi.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@ecoi.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@ecoi.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@ecoi.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.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.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@ecoi.co.in	Bihar, Jharkhand		

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, 2015 and only a simplified version prepared for general information. Policy Holders are advised to refer to the Insurance Act as amended from time to time for complete and accurate details.]

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 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 the insurance Act 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 the insurance Act as amended from time to time for complete and accurate details.]