



# THE ORIENTAL INSURANCE COMPANY LIMITED

Regd. Office : Oriental House, P.B. No. 7037, A-25/27, Asaf Ali Road, New Delhi - 110 002

## PROSPECTUS

### HOPE – HEALTH OF PRIVILEGED ELDER (SENIOR CITIZEN SPECIFIED DISEASES INSURANCE)

#### **SALIENT FEATURES OF THE POLICY:**

- Exclusively designed for Citizens aged 60 years and above
- Policy is available for Sum Insured 1 lac, 2 lac, 3 lac, 4 lac and 5 lacs.
- Covers specified diseases only.
- Compulsory co-payment of 20% on admissible claim amount.
- Discount in premium for opting Voluntary Co-payment.
- No claim discount in premium.
- Loading for new entrants.
- Benefit of continuity extended if already insured with any mediclaim policy of the Company.
- TPA service available.
- **Cashless Service through TPA only and limited to Rs. 1 lakh.**

This policy is available to any Indian citizen who is aged 60 years and above and for hospitalisation in India only.

The proposer has to submit any of the following documents as age proof:

- (a) Birth Certificate
- (b) Matriculation Certificate
- (c) School Leaving Certificate
- (d) Photo Voter Identity Card
- (e) Driving Licence
- (f) PAN Card
- (g) Passport

The Policy reimburses the payment of hospitalisation and / or domiciliary hospitalisation expenses for the specified diseases contracted or injury sustained by the insured persons. The settlement of the claim will be done by the TPA either to the network hospital or to the insured.

**1.1 Only the following Specified Diseases / illness/ injury are covered under the policy and the maximum liability of the Company in respect thereof shall be as follows:**

Sr. No.	Name of Disease	Maximum Limit of Liability per illness (including domiciliary hospitalisation benefit, if any)
1.	Accidental Injury	100% of Sum Insured
2.	Knee Replacement	70% of Sum Insured
3.	Cardio Vascular Diseases	50% of Sum Insured
4.	Chronic Renal Failure	50% of Sum Insured

5.	Cancer	50% of Sum Insured
6.	Hepato-Biliary Disorders	50% of Sum Insured
7.	Chronic Obstructive Lung Diseases	20% of Sum Insured
8.	Stroke	20% of Sum Insured
9.	Benign Prostrate	15% of Sum Insured
10.	Orthopaedic Diseases	15% of Sum Insured
11.	Ophthalmic Diseases	10% of Sum Insured

Note: Company's Liability in respect of all claims admitted during the Period of insurance shall not exceed the Sum Insured per Person mentioned in the Policy / Schedule.

**1.2 REASONABLE & NECESSARY EXPENSES UPTO THE FOLLOWING LIMITS ARE PAYABLE / REIMBURSABLE UNDER THE POLICY, FOR THE SPECIFIED DISEASES / ILLNESS/ INJURY ONLY, WITHIN THE OVERALL LIMIT AS SPECIFIED ABOVE:**

- a. Room, Boarding and Nursing Expenses as provided by the Hospital /Nursing Home not exceeding 1% of the Sum Insured per day.
- b. I.C. Unit expenses not exceeding 2% of the Sum Insured per day.  
(Stay in the Room and the stay in I.C.U., if required, should not exceed total number of days of admission in the hospital).
- c. Ambulance Services Charges per illness by registered ambulance – Actual Expenses or Rs 1000/- whichever is less shall be reimbursable in case patient has to be shifted from residence to hospital in case of admission in Emergency Ward / I.C.U. Or from one Hospital / Nursing home to another Hospital / Nursing Home for hospitalisation.
- d. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees.
- e. Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, Artificial Limbs, Cost of Prosthetic devices implanted during surgical procedure like pacemaker, Relevant Laboratory / Diagnostic test, X-Ray etc..

Note: Only reasonable and necessary expenses based on the severity (**minor / medium / major**) of the Specified Diseases / illness/ injury will be payable under the policy but not exceeding the maximum limit irrespective of the expenses incurred by the insured.

**2 DEFINITIONS:**

2.1 “**HOSPITAL/NURSING HOME:** means any institution in India established for indoor care and treatment of sickness and injuries and which either

- a) Is duly licensed and registered as a Hospital or Nursing Home with the appropriate authorities and is under the supervision of a registered and qualified Medical Practitioner.

OR

- b) In areas where licensing and registration facilities with appropriate authorities are not available, the institution must be one recognised by local authority as Hospital / Nursing Home and should comply with minimum criteria as under:
  - i. It should have at least 15 in-patient medical beds in case of Metro cities, A Class cities & B class cities or 10 in- patient medical beds in case of “C class” cities. **Classification of cities shall be as per Govt of India Notifications issued in this respect from time to time.**

- ii. Fully equipped and engaged in providing Medical and Surgical facilities along with Diagnostic facilities i.e. Pathological test and X-ray, E.C.G. etc for the care and treatment of injured or sick persons as in-patient.
- iii. Fully equipped operation theatre of its own, where surgical operations are carried out.
- iv. Fully qualified nursing staff under its employment round the clock.
- v. Fully qualified Doctor(s) should be physically in-charge round the clock.

The term 'Hospital/Nursing Home' shall not include an establishment which is a place of rest, a place for the aged, a place for drug addicts or a place for alcoholics, a hotel or a similar place.

**Note: In case of Ayurvedic / Homeopathic / Unani treatment, Hospitalisation expenses are admissible only when the treatment is taken as in-patient, in a Government Hospital / Medical College Hospital.**

2.2 Surgical Treatment means manual and/ or operative procedures for correction of deformities / defects and injuries, cure of diseases, relief of suffering and prolongation of life.

2.3 **HOSPITALISATION PERIOD:** Expenses on Hospitalisation are admissible only if hospitalisation is for a minimum period of 24 (Twenty Four) hours. However,

(A) This time limit shall not apply to following specific treatments taken in the Networked Hospital / Nursing Home where the Insured is discharged on the same day. Such treatment shall be considered to be taken under Hospitalisation Benefit.

- i. Haemo Dialysis,
- ii. Parenteral Chemotherapy,
- iii. Radiotherapy,
- iv. Eye Surgery,
- v. Lithotripsy (kidney stone removal),
- vi. Dental surgery following an accident
- vii. Coronary Angioplasty
- viii. Coronary Angiography
- ix. Surgery of Gall bladder, Pancreas and bile duct
- x. Surgery of Prostrate.
- xi. Treatment of fractures / dislocation excluding hair line fracture, Contracture releases and minor reconstructive procedures of limbs which otherwise require hospitalisation.
- xii. Arthroscopic Knee surgery.
- xiii. Laproscopic therapeutic surgeries.
- xiv. Surgery under General Anaesthesia.
- xv. Or any such procedure agreed by TPA/Company before treatment.

(B) Further if the treatment / procedure / surgeries of above diseases are carried out, in Networked specialised Day Care Centre which is fully equipped with advanced technology and specialised infrastructure where the insured is discharged on the same day, the requirement of minimum beds shall be waived provided following conditions are complied with.

- i. The operation theatre is fully equipped for the surgical operation required in respect of sickness / ailment / injury for which treatment is being taken.
- ii. Day Care nursing staff is fully qualified.

- iii. The doctor performing the surgery or procedure as well as post operative attending doctors are also fully qualified for the specific surgery / procedure.

(C) This condition of minimum 24 (Twenty Four) hours Hospitalisation shall also not apply provided:

- I) The treatment is such that it necessitates hospitalisation and the procedure involves specialised infrastructural facilities available only in hospitals,
- BUT
- II) Due to technological advances hospitalisation is not required for 24 (Twenty Four) hours.
- AND / OR
- iii) Surgical procedure involved has to be done under General Anaesthesia.

**ABOVE ARE ADMISSIBLE SUBJECT TO TERMS & CONDITIONS OF THE POLICY.**

**NOTE: PROCEDURES / TREATMENTS USUALLY DONE IN OUT- PATIENT DEPARTMENT ARE NOT PAYABLE UNDER THE POLICY EVEN IF CONVERTED TO DAY CARE SURGERY / PROCEDURE OR AS IN- PATIENT IN THE HOSPITAL FOR MORE THAN 24 (Twenty Four) HOURS.**

**2.4 DOMICILIARY HOSPITALISATION BENEFIT:** means Medical treatment for a period exceeding three days for such covered illness/disease/injury which in the normal course would require care and treatment at a hospital / nursing home as in-patient but actually taken whilst confined at home in India under any of the following circumstances:

- i. The condition of the patient is such that he/she cannot be removed to the Hospital/Nursing Home
- OR
- ii. The patient cannot be removed to Hospital/Nursing home due to lack of accommodation in any hospital in that city / town / village.

**Subject however to the condition that Domiciliary Hospitalisation benefit shall not cover**

- a) Expenses incurred for pre and post hospital treatment and
- b) Expenses incurred for treatment for any of the following diseases :
  - i. Chronic Nephritis and Nephritic Syndrome,
  - ii. Pyrexia of unknown origin for less than 10 days,
  - iii. Upper Respiratory Tract infection including Laryngitis and Pharyngitis,
  - iv. Arthritis, Gout and Rheumatism.

**Note: DOMICILIARY HOSPITALISATION BENEFIT shall not exceed Rs. 20,000/- (Twenty Thousand rupees) per insured in respect of all claims admitted during the policy period.**

### **3 ADDITIONAL DEFINITIONS :**

**3.1 SENIOR CITIZEN:** Means an Indian citizen who has attained the age of 60 (sixty) years as on the date of proposal.

**3.2 INSURED PERSON:** Means Person(s) named on the schedule of the policy.

- 3.3 SPECIFIED DISEASES:** The diseases as mentioned in para 1 above.
- 3.4 ENTIRE CONTRACT:** This policy / proposal and declaration given by the insured constitute the complete contract of this policy. Only Insurer may alter the terms and conditions of this policy. Any alteration that may be made by the insurer shall only be evidenced by a duly signed and sealed endorsement on the policy.
- 3.5 THIRD PARTY ADMINISTRATOR (TPA):** means any Company who has obtained licence from IRDA to practice as a third party administrator and is appointed by the Company.
- 3.6 NETWORK HOSPITAL:** means hospital that has agreed with the TPA to participate for providing cashless health services to the insured persons. The list is maintained by and available with the TPA and the same is subject to amendment from time to time.
- 3.7 HOSPITALISATION PERIOD:** The period for which an insured person is admitted in the hospital as inpatient and stays there for the sole purpose of receiving the necessary and reasonable treatment for the covered disease / ailment contracted / injuries sustained during the period of policy. The minimum period of stay shall be 24 (Twenty Four) hours.
- 3.8 PRE-HOSPITALISATION:** Relevant medical expenses incurred during the period upto 30 (Thirty) days prior to hospitalisation on covered disease/ illness/ injury sustained shall be considered as part of claim mentioned under item 1.2 above.
- 3.9 POST-HOSPITALISATION:** Relevant medical expenses incurred for the immediate period of 60 (sixty) days after hospitalisation (i.e. after discharge from hospital) on covered disease/illness/injury sustained shall be considered as part of claim mentioned under item 1.2 above.
- 3.10 MEDICAL PRACTITIONER:** means a person who holds a degree/diploma of a recognised institution and is registered by Medical Council of any State of India. The term Medical Practitioner would include Physician, Specialist and Surgeon.
- 3.11 QUALIFIED NURSE:** means a person who holds a certificate of a recognised Nursing Council.
- 3.12 PRE EXISTING HEALTH CONDITION OR DISEASE:** means any ailment / disease / injuries that the person is suffering from, (treated / untreated, declared or not declared in the proposal form) while taking a policy for the first time.
- Further any complications arising from pre-existing ailment / disease / injuries shall be considered as a part of that pre existing health condition or disease.
- 3.13 IN-PATIENT:** An Insured person who is admitted to hospital and stays for at least 24 (Twenty Four) hours for the sole purpose of receiving the treatment for covered ailment / illness / disease / injury / accident during the currency of the policy.

- 3.14 **CASHLESS FACILITY:** means the TPA may authorise upon the Insureds' request for direct settlement of admissible claim as per agreed charges between Net work Hospitals & the TPA. In such cases the TPA shall directly settle all eligible amounts with the Net work Hospitals.
- 3.15 **I.D. CARD:** means the card issued to the Insured Person by the TPA to avail Cashless facility in the Network Hospital.
- 3.16 **DAY CARE PROCEDURE:** means the course of Medical treatment / surgical procedure listed at 2.3 (A) carried out, in Networked specialised Day Care Centre which is fully equipped with advanced technology and specialised infrastructure where the insured is discharged on the same day, the requirement of minimum beds shall be waived provided other conditions are complied with.
- 3.17 **LIMIT OF INDEMNITY:** means the amount stated in the schedule against the name of each insured person which represents maximum liability for any and all claims made during the policy period in respect of that insured person in respect of hospitalization taking place during currency of the policy.
- 3.18 **ANY ONE ILLNESS:** Any one illness shall be deemed to mean continuous period of illness and it includes relapse within 105 days from the date of discharge from the Hospital / nursing home from where the treatment was taken. Occurrence of the same illness after a lapse of 105 days as stated above shall be considered as fresh illness for the purpose of this policy.
- 3.19 **PERIOD OF POLICY:** This insurance policy is issued for a period of one year as shown in the schedule.
- 3.20 **REASONABLE AND NECESSARY EXPENSES:** shall mean the cost of surgical / medical treatment that is reasonably and necessarily incurred for treating the disease / illness / injury for which insured person is hospitalised. In the case of a networked hospital this shall be as per the pre-agreed rate between Networked Hospital and the TPA. Any additional expenses have to be borne by the insured.
- 3.21 **Compulsory Co-Payment:** Insured has to bear 20% (Twenty percent) of admissible claim amount in each and every claim. Admissible claim amount for this purpose will be lower of the actual admissible expenses incurred by the client or the limit specified under Table in para numbered 1.
- 3.22 **Voluntary Co-Payment:** The insured may opt to bear a part of the claim amount (in addition to compulsory co-payment) for which following discounts are applicable, subject to a maximum of 50% (Fifty percent)

Co-payment Opted	Discount available on premium
10%	10%
20%	20%
30%	30%
40%	40%
50% & above	50%

**3.23 No Claim Discount:** The insured shall be entitled for No Claim Discount at the rate of 5% (Five percent) of the renewal premium payable after every claim free policy year, subject to a maximum of 20% (Twenty percent), as per table below, provided the policy is renewed without any break:

Discount available on renewal premium payable after one (or the first) claim free annual policy	<b>5%</b>
Discount available on renewal premium payable on second continuous claim free renewal of annual Policy	<b>10%</b>
Discount available on renewal premium payable on third continuous claim free renewal of annual Policy	<b>15%</b>
Discount available on renewal premium payable on fourth continuous claim free renewal of annual Policy	<b>20%</b>

**No Claim Discount shall become 'nil' once a claim is paid or becomes payable under the policy, irrespective of the amount of claim.**

**For No Claim Discount, renewal of this particular policy shall only be considered and no benefit of any other insurance policy shall be allowed.**

At the discretion of the Company where policy is renewed within 7 (seven) days from the expiry date, the renewal is permissible with the applicable No Claim Discount.

**3.24 Break in Insurance:** Break in insurance upto 7 (seven) days may be condoned at the discretion of the Company, and in such cases the No Claim Discount and Health Check Up Benefit shall be unaffected.

#### **4 EXCLUSIONS:**

The Company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any Insured Person in connection with or in respect of:

**4.1 Any disease / health condition / illness / ailment or any condition arising therefrom other than those specified in the policy as covered.**

**4.2 Pre-existing health condition or disease or ailment / injuries:** Any ailment / disease / injuries / health condition which are pre-existing (treated / untreated, declared / not declared in the proposal form), when the cover incepts for the first time are excluded upto 2 (two) years of this policy being in force continuously.

For the purpose of applying this condition, the date of inception of the Mediclaim policy taken from **the Company** shall be considered, provided the renewals have been continuous and without any break in period.

This exclusion shall also apply to any complications arising from pre existing ailments / diseases / injuries. Such complications shall be considered as a part of the pre existing health condition or disease. To illustrate if a person is suffering from hypertension or diabetes or both hypertension and diabetes at the time of taking the policy, then policy shall be subject to following exclusions.

<b>Diabetes</b>	<b>Hypertension</b>	<b>Diabetes &amp; Hypertension</b>
Diabetic Retinopathy	Cerebro Vascular accident	Diabetic Retinopathy
Diabetic Nephropathy	Hypertensive Nephropathy	Diabetic Nephropathy

Diabetic Foot /wound	Internal Bleed/ Haemorrhages	Diabetic Foot
Diabetic Angiopathy	Coronary Artery Disease	Diabetic Angiopathy
Diabetic Neuropathy		Diabetic Neuropathy
Hyper / Hypoglycaemic shocks		Hyper / Hypoglycaemic shocks
		Coronary Artery Disease
		Cerebro Vascular accident
		Hypertension Nephropathy
		Internal Bleeds/ Haemorrhages

4.3 Any disease **covered under the policy** other than those stated in clause 4.4, contracted by the Insured person during the first 30 (Thirty) days from the commencement date of the policy except treatment for accidental injuries.

**4.4 The expenses on treatment of following ailments / diseases / surgeries for first two policy years are not payable.**

- i Non infective Arthritis.
- ii Cataract.
- iii Surgery of benign prostatic hypertrophy.
- iv Surgery of gallbladder and bile duct excluding malignancy.
- v Surgery of genito urinary system excluding malignancy.
- vi Gout and Rheumatism.
- vii Calculus diseases.
- viii Joint Replacement due to Degenerative condition.
- ix Age related osteoarthritis and Osteoporosis.

**If the continuity of the renewal is not maintained with the Company then subsequent cover shall be treated as fresh policy and clauses 4.2, 4.3, 4.4 shall apply afresh unless agreed by the Company and suitable endorsement is passed on the policy.**

4.5 Injury or disease directly or indirectly caused by or arising from or attributable to War, Invasion, Act of Foreign Enemy, War like operations (whether war be declared or not) or by nuclear weapons / materials.

4.6 Circumcision (unless necessary for treatment of a disease included hereunder or as may be necessitated due to any accident), vaccination, inoculation or change of life or cosmetic or of aesthetic treatment of any description, hair transplant, plastic surgery other than as may be necessitated due to an accident or as a part of any illness / disease.

4.7 Surgery for correction of eye sight, cost of spectacles, contact lenses, hearing aids etc.

4.8 Convalescence, general debility, "run down" condition or rest cure, congenital external diseases or defects or anomalies, sterility, any fertility, sub-fertility or assisted conception procedure, venereal diseases, intentional self-injury/suicide, all psychiatric and psychosomatic disorders and diseases / accident due to and or use, misuse or abuse of drugs / alcohol or use of intoxicating substances or such abuse or addiction etc.

4.9 All expenses arising out of any condition directly or indirectly caused by, or associated with Human T-cell Lymphotropic Virus Type III (HTLD - III) or Lymphadenopathy Associated Virus (LAV) or the Mutants Derivative or Variations

Deficiency Syndrome or any Syndrome or condition of similar kind commonly referred to as AIDS, HIV and its complications including sexually transmitted diseases..

- 4.10 Expenses incurred at Hospital or Nursing Home primarily for evaluation / diagnostic purposes which is not followed by active treatment for the ailment during the hospitalised period.
- 4.11 Expenses on vitamins, tonics, mineral water and allied items unless forming part of treatment for injury or disease as certified by the attending physician.
- 4.12 Naturopathy treatment, unproven procedure or treatment, experimental or alternative medicine and related treatment including acupressure, acupuncture, magnetic and such other therapies etc.
- 4.13 Expenses incurred for investigation or treatment irrelevant to the diseases diagnosed during hospitalisation or primary reasons for admission. Private nursing charges, Referral fee to family doctors, Out station consultants / Surgeons fees etc.
- 4.14 External and / or durable Medical / Non medical equipment like Ambulatory devices i.e. Walker , Crutches, Belts ,Collars ,Caps , Splints, Slings, Braces ,Stockings etc of any kind, CPAP, CAPD, Infusion pump, Diabetic foot wear, Glucometer / Thermometer, nebuliser and similar related items etc and also any medical equipment which is subsequently used at home etc.
- 4.15 All non medical expenses including Personal comfort and convenience items or services such as telephone, television, Aya / barber or beauty services, diet charges, baby food, cosmetics, napkins , toiletry items etc, guest services and similar incidental expenses or services etc..
- 4.16 Change of treatment from one system of medicine to another unless necessitated and agreed / allowed by the TPA / Company.
- 4.17 Treatment of obesity or condition arising therefrom (including morbid obesity) and any other weight control programme, services or supplies etc.
- 4.18 Any treatment required arising from Insured's participation in any hazardous activity such as scuba diving, motor racing, parachuting, hang gliding, rock or mountain climbing, other allied similar activities etc.
- 4.19 Any treatment received in convalescent home, convalescent hospital, health hydro, nature care clinic or similar establishments.
- 4.20 Any stay in the hospital for any domestic reason or where no active regular medical treatment is given by the specialist / physician.
- 4.21 Out Patient Diagnostic, Medical or Surgical procedures or treatments, non-prescribed drugs and medical supplies.
- 4.22 Massages, Steam bathing, Shirodhara and like treatment under Ayurvedic treatment.
- 4.23 Any kind of Service charges, Surcharges, Admission fees / Registration charges, File Charges etc levied by the hospital.

4.24 Doctor's home visit charges, Attendant / Nursing charges during pre and post hospitalisation period.

4.25 Treatment which is continued before hospitalization and continued even after discharge for an ailment / disease / injury other than the one for which hospitalisation claim is made / admissible.

## 5 CONDITIONS

5.1 **ENTIRE CONTRACT:** the policy, proposal form, prospectus and declaration given by the insured shall constitute the complete contract of insurance. Only insurer may alter the terms and conditions of this policy/ contract. Any alteration that may be made by the insurer shall only be evidenced by a duly signed and sealed endorsement on the policy.

5.2 **COMMUNICATION:** Every notice or communication to be given or made under this policy shall be delivered in writing at the address of the policy issuing office / Third Party Administrator as shown in the Schedule.

5.3 **PAYMENT OF PREMIUM:** The premium payable under this policy shall be paid in advance. No receipt for premium shall be valid except on the official form of the Company signed by a duly authorized official of the company. The due payment of premium and the observance and fulfilment of the terms, provisions, conditions and endorsements of this policy by the Insured Person in so far as they relate to anything to be done or complied with by the Insured Person shall be condition precedent to any liability of the Company to make any payment under this policy. No waiver of any terms, provisions, conditions and endorsements of this policy shall be valid, unless made in writing and signed by an authorised official of the Company.

5.4 The policy shall be deemed to be void ab-inito (since its inception) if the payment instrument is dishonoured for any reasons whatsoever and under this circumstance the Company shall not admit any liability whatsoever under this policy.

5.5 **NOTICE OF CLAIM:** Immediate notice of claim with particulars relating to Policy Number, ID Card No., Name of insured person in respect of whom claim is made, Nature of disease / illness / injury and Name and Address of the attending medical practitioner / Hospital/Nursing Home etc. should be given to the Company / TPA while taking treatment in the Hospital / Nursing Home by Fax, Email. Such notice should be given within 48 hours of admission or before discharge from Hospital / Nursing Home, whichever is earlier, unless waived in writing by the Company.

5.6 **CLAIM DOCUMENTS:** Final claim along with hospital receipted original Bills/Cash memos/reports, claim form and list of documents as listed below should be submitted to the Company / TPA within 7 (seven) days of discharge from the Hospital / Nursing Home.

- a. Original bills, receipts and discharge certificate / card from the hospital.
- b. Medical history of the patient recorded by the Hospital.

- c. Original Cash-memo from the hospital (s) / chemist (s) supported by proper prescription.
- d. Original receipt, pathological and other test reports from a pathologist / radiologist including film etc supported by the note from attending medical practitioner / surgeon demanding such tests.
- e. Attending Consultants / Anaesthetists / Specialist certificates regarding diagnosis and bill / receipts etc.
- f. Surgeon's original certificate stating diagnosis and nature of operation performed along with bills / receipts etc.
- g. Any other information / document required by TPA / Insurance Company.

All documents must be duly attested by the insured person.

In case of post hospitalisation treatment [limited to 60 (sixty) days] all supporting claim papers / documents as listed above should also be submitted within 7 (seven) days after completion of such treatment [ upto 60 (sixty) days or actual period which ever is less ] to the Company / T.P.A. In addition insured should also provide the Company / TPA such additional information and assistance as the Company / TPA may require in dealing with the claim.

**NOTE:** Waiver of the condition may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the insured was placed it was not possible for him or any other person on behalf of the insured to give such notice or file claim within the prescribed time limit. Otherwise Company / TPA has a right to reject the claim.

#### **5.7 PROCEDURE FOR AVAILING CASHLESS ACCESS SERVICES IN NETWORK HOSPITAL/NURSING HOME :**

- i) Claim in respect of Cashless Access Services shall be through the TPA provided admission is in a listed hospital in the agreed list of the networked Hospitals / Nursing Homes and is subject to pre admission authorization. The TPA shall, upon getting the related medical details / relevant information from the insured person / network Hospital / Nursing Home, verify that the person is eligible to claim under the policy and after satisfying itself shall issue a pre-authorisation letter / guarantee of payment letter to the Hospital / Nursing Home mentioning the sum guaranteed as payable, also the ailment for which the person is seeking to be admitted as in-patient.
- ii) The TPA reserves the right to deny pre-authorisation in case the hospital / insured person is unable to provide the relevant information / medical details as required by the TPA. In such circumstances denial of Cashless Access should in no way be construed as denial of claim and / or deficiency of service. The insured person may obtain the treatment as per his/her treating doctor's advice and later on submit the full claim papers to the TPA for reimbursement within 7 (seven) days of the discharge from Hospital / Nursing Home.

- iii) In case any information available to the TPA / Company which makes the claim inadmissible or doubtful requiring investigations, the authorisation of cashless facility shall be withdrawn. However this shall be done by the TPA before the patient is discharged from the Hospital.

#### 5.8 NON ADMISSION OF CLAIM:

A (I): Where the policy is being serviced by TPA, it shall repudiate the claim if not covered / not payable under the policy. The TPA shall mention the reasons for repudiation in writing to the insured person. The insured person may approach the policy issuing office of the Company for any grievance relating to the claim. The Company's decision in this regard shall be final and binding on TPA.

A (II): Where the policy is serviced by the Company and in case of repudiation of the claim, insured may approach the concerned Regional Office of the Company for redressal of any grievance relating to the claim.

B: In case claim is repudiated by the Company as per A (1) & A (II) the insured person may approach the **Chief Manager Grievance Cell of the Company's Regd. Office situated at A-25/27, Asaf Ali Road, New Delhi-110002.**

C: The Central Government has established office of the Insurance Ombudsman for redressal of grievances and the insured may approach the Insurance Ombudsman for redressal of his grievance. The insured may visit the site at <http://www.ombudsmanindia.org/> for details.

5.9 Any medical practitioner authorised by the TPA/Company shall be allowed to examine the Insured Person with / without prior notice in case of any alleged injury or Disease requiring Hospitalisation when and so often as the same may reasonably be required on behalf of the TPA/Company.

**5.10 FRAUD / MISREPRESENTATION / CONCEALMENT:** The Company shall not be liable to make any payment under this policy in respect of any claim, if such claim be in any manner (intentionally or recklessly or otherwise) misrepresented or concealed or involve any non disclosure of material facts or making false statements or submitting fake bills whether by the Insured Person or Institution / Organization on his behalf. Such action shall render this policy null and void and all claims hereunder shall be forfeited. Company may take suitable legal action against the Insured Person / Institution / Organization as per Law.

**5.11 CONTRIBUTION:** If at the time when any claim arises under this policy, there is in existence any other insurance (other than Cancer Insurance Policy in collaboration with Indian Cancer Society) whether it be effected by or on behalf of any Insured Person in respect of whom the claim may have arisen covering the same loss, liability, compensation, costs or expenses, the company shall not be liable to pay or contribute more than its rateable proportion of any loss, liability, compensation, costs or expenses. The benefits under this policy shall however be in excess of the benefits available under Cancer Insurance Policy.

**5.12 CANCELLATION CLAUSE:** Company may at any time, cancel this Policy by sending the Insured 30 (Thirty) days notice by registered letter at the Insured's last known address and in such an event the Company shall refund to the Insured a pro-rata premium for un-expired Period of Insurance. *(such*

***cancellation by the Company may be for reasons such as intentional misrepresentation / malicious suppression of facts intended to misleading the insurance company about the acceptability of the proposal, lodging a fraudulent claim and such other intentional acts of the insured / beneficiaries under the policy).*** The Company shall, however, remain liable for any claim which arose prior to the date of cancellation. The Insured may at any time cancel this policy and in such event the Company shall allow refund of premium at Company's short period rate only (table given here below) provided no claim has occurred during the policy period up to date of cancellation.

<b>Period on Risk</b>	<b>Rate of premium to be charged</b>
Upto 1 Month	1/4th of the annual rate
Upto 3 Months	1/2 of the annual rate
Upto 6 Months	3/4th of the annual rate
Exceeding 6 months	Full annual rate

**5.13 ARBITRATION CLAUSE:** If any dispute or difference shall arise as to the quantum to be paid under the policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties or if they cannot agree upon a single arbitrator within 30 (Thirty) days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.

It is clearly agreed and understood that no difference or dispute shall be referable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of this policy.

It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this policy that award by such arbitrator/ arbitrators of the amount of the loss or damage shall be first obtained.

**5.14 DISCLAIMER OF CLAIM:** It is also hereby further expressly agreed and declared that if the TPA/Company shall disclaim liability in writing to the Insured for any claim hereunder and such claim shall not within 12 calendar months from the date of such disclaimer have been made the subject matter of a suit in a court of law, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

**5.15 PAYMENT OF CLAIM:** The policy covers illness, disease or accidental bodily injury sustained by the insured person during the policy period any where in India and all medical / surgical treatment under this policy shall have to be taken in India and admissible claims thereof shall be payable in Indian currency without any interest thereof.

- a) Payment of claim shall be made through TPA to the Hospital / Nursing Home or to the Insured Person in case policy is serviced through TPA.
- b) In non TPA case the claim shall be paid to the insured person by the Company.

6. **COST OF HEALTH CHECK** : The Insured shall be entitled for reimbursement of cost of Health check up undertaken once at the expiry of a block of every four continuous claim free underwriting years provided there are no claims reported during the block. The cost so reimbursable shall not exceed the amount equal to 1% of the average sum Insured during the block of four claim free underwriting years.

**IMPORTANT**

Both Health Check-up and No Claim Discount provisions are applicable only in respect of continuous insurance without break.

7. **PERIOD OF POLICY**: This insurance policy is issued for a period of one year.
8. **RENEWAL OF POLICY**:
- a) The Company shall not be responsible or liable for non-renewal of policy due to non-receipt or delayed receipt (i.e. After the due date) of the proposal form or of the medical practitioners report wherever required or due to any other reason whatsoever.
  - b) Notwithstanding this, however, the decision to accept or reject for coverage of any person and / or upon renewal of this insurance, shall rest solely with the Company. The company may at its discretion revise the premium rates and / or the terms & conditions of the policy every year at the time of renewal thereof (if called for). **Renewal of this policy is not automatic**; premium due must be paid by the proposer to the company before the due date.
  - c) The Company is under no obligation to send renewal notice and its absence thereof shall not tantamount to deficiency in services.
  - d) The Company is under no obligation to renew the Policy merely on receipt of premium unless acceptance of renewal is conveyed by issuing renewed policy with receipt.

If the Insured desires to renew the policy for enhanced Sum Insured, then the Additional Sum Insured shall be accepted subject to satisfactory medical check up at insured's cost. The Additional Sum Insured, if accepted, shall be treated as if a separate policy has been issued for that Additional Sum and the restrictions as applicable to a fresh policy shall apply for that Additional Sum Insured.

9. **PRE-ACCEPTANCE HEALTH CHECKUP**: Any person desiring to take fresh insurance cover has to submit following medical reports (and any other medical reports) required by the company from authorised Network Diagnostic Centre.

This provision shall also be applicable for renewal where there is a break in policy period.

The cost of such check up shall be borne by the insured. However in case of fresh proposals, the Company shall deduct lowest of the following from the premium amount provided the proposal is accepted by the Company:

50% cost of Medical Check up or 10% of premium chargeable or Rs.1000/- (Rupees one thousand) per person.

However in case of break in policy period there will be no reimbursement of pre acceptance health check up cost.

MEDICAL TEST	PHYSICAL EXAMINATION
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	URINE(MICROALBUMIN UREA)
	GLYCOCYLATED HAEMOGLOBIN
	ULTRASONOGRAPHY (WHOLE ABDOMEN AND PELVIS)
	X-RAY BOTH KNEES (ANTEPOSTERIOR AND LATREL)
	COMPLETE EYE TEST INCLUDING FUNDUS ETC
	STRESS TEST (TMT)

10. **SUM INSURED:** The Company's liability in respect of all claims admitted during the period of Insurance shall not exceed the sum insured opted by the Insured person. Minimum sum insured that can be selected is Rs 100,000/- and higher sum insured can be selected in multiples of Rs 100,000/- upto a maximum sum insured of Rs. 5,00,000/-.

**11. AUTHORITY TO OBTAIN RECORDS:**

- a) The insured person agrees to and authorises the disclosure to the insurer or the TPA or any other person nominated by the insurer of any and all Medical records and information held by any Institution / Hospital or Person from which the insured person has obtained any medical or other treatment to the extent reasonably required by either the insurer or the TPA in connection with any claim made under this policy or the insurer's liability thereunder.
- b) The insurer and the TPA agree that they shall preserve the confidentiality of any documentation and information that comes into their possession pursuant to (a) above and shall only use it in connection with any claim made under this policy or the insurer's liability thereunder

12. **CHANGE OF ADDRESS:** Insured must inform the company immediately in writing of any change in the address.

13. **QUALITY OF TREATMENT :** The insured acknowledges and agrees that payment of any claim by the insurer shall not constitute on part of the insurance company a guarantee or assurance as to the quality or effectiveness of any medical treatment obtained by the insured person, it being agreed and recognized by the policy holder that insurer is not in any way responsible or liable for the availability or quality of any services (Medical or otherwise) rendered by any institution (including a network hospital) whether pre-authorized or not.

14. **ID CARD:** The card issued to the insured person by the TPA to avail cash less facility in the Network Hospital only. Upon the cancellation or non renewal of this policy, all ID cards shall immediately be returned to the TPA at the policy holders expense and the policy holder undertakes to indemnify the insurer /TPA for any liability whatsoever due to any misuse of the ID card by any person whomsoever.

15. **Protection of Policyholders' Interest:** This policy is subject to IRDA (Protection of Policyholders' Interest) Regulation.

16. In case of any grievance not redressed by the concerned Policy issuing Office, the insured person shall have a right to appeal / approach the **Chief Manager Grievance Cell of the Company's Regd. Office situated at A-25/27, Asaf Ali Road, New Delhi-110002.**

The Central Government has also established office of the Insurance Ombudsman for redressal of policyholders' grievances. The insured may visit the site at <http://www.ombudsmanindia.org/> for details.

**17. SCHEDULE OF PREMIUM:**

Age Group	Sum Insured (in Rs.)				
	100000	200000	300000	400000	500000
	Premium (in Rs.)				
<b>60-65</b>	4500	8700	12400	16100	19700
<b>66-70</b>	4800	9100	13100	16900	20700
<b>71-75</b>	5700	11400	16300	21500	26100
<b>76-80</b>	6100	12000	17100	22700	27600
<b>Above 80</b>	6400	12600	18100	23800	29000

**Premium will be loaded by 10% for new entrants.**

This Prospectus shall form part of your proposal form. Signatures hereunder confirm that you have noted the contents of the prospectus.

Name: \_\_\_\_\_ Signature  
 Address: \_\_\_\_\_  
 Place: \_\_\_\_\_ Date: \_\_\_\_\_

Note: For legal interpretation only English version will be valid.

**INSURANCE ACT 1938 SECTION 41 - PROHIBITION OF REBATE**

Section 41 of the Insurance Act 1938 provides as follows:

Any person making default in complying with provision of this section shall be punishable with fine, which may extend to Rs.500/-.

**No person shall allow, or offer to allow, either directly or indirectly as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy nor shall any person taking out or renewing or continuing a policy accept any rebate except such rebate as may be allowed in accordance with the published prospectus or tables of the Insurer.**