National Insurance Company Limited

CIN - U10200WB1906GOI001713 IRDAI Regn. No. - 58

National Super Top Up Mediclaim Policy

PROSPECTUS

1.1 Product

National Super Top Up Mediclaim Policy is a high threshold health insurance product, covering the members of a family under a single sum insured on floater basis or each member on individual sum insured basis. Claim under the Policy is payable provided the cumulative medical expenses for the insured (individual basis) or the family (floater basis) in a policy period exceeds the threshold. The Policy covers expenses in respect of inpatient treatment (allopathy, ayurveda and homeopathy) reasonably and customarily incurred for treatment of a disease or an injury contracted/sustained during the policy period. The Policy also covers pre hospitalisation and post hospitalisation expenses, 140+ day care procedures/surgeries, organ donor's medical expenses, hospital cash, doctor's home visit, nursing, aya and attendant charges, ambulance charges, HIV/ AIDS treatment, bariatric surgery and maternity.

Important:

1. Claim shall be admissible for the hospitalisation during which the cumulative medical expenses in respect of hospitalisation(s) of any insured person (individual plan) or one or more insured persons (floater plan) in a policy period exceeds the threshold and for all subsequent hospitalisation(s) during the policy period.
2. Threshold shall be determined taking into account the Cumulative Medical Expenses incurred in one or more hospitalisation(s) during the policy period of this Policy for Coverage mentioned in Section 1.2 only, irrespective of existence of any Base Policy covering the said hospitalisation(s).
3. For claims admissible under the Policy (after Cumulative Medical Expenses exceeds the Threshold) Coverage mentioned in both Section 1.2 and Section 1.3 shall be payable.
4. Maximum liability of the Company under the policy for all admissible claims during the policy period shall be the individual/ floater sum insured opted.
5. **The insured shall preserve and submit all original documents and/ or certified copies of documents related to all hospitalisation(s) during the policy period to enable the Company to calculate the cumulative medical expenses and threshold, for determining admissibility and payment of claims.**

1.2 Coverage

1.2.1 In-patient Treatment

The Company shall pay to the hospital or reimburse the insured, the medical expenses for:

i. Room charges and intensive care unit charges (including diet charges, nursing care by qualified nurse, RMO charges, administration charges for IV fluids/blood transfusion/injection)
ii. Medical practitioner(s)
iii. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances
iv. Medicines and drugs
v. Diagnostic procedures
vi. Prosthetics and other devices or equipment if implanted internally during a surgical procedure.
vii. Dental treatment, necessitated due to an injury
viii. Plastic surgery, necessitated due to illness or injury
ix. Hormone replacement therapy, if medically necessary
x. Vitamins and tonics, forming part of treatment for illness/injury as certified by the attending medical practitioner
xi. Circumcision, necessitated for treatment of an illness or injury

1.2.2 Pre Hospitalisation

The Company shall reimburse the insured the medical expenses incurred up to thirty days immediately before the insured person is hospitalised, provided that:

i. such medical expenses are incurred for the same condition for which the insured person's hospitalisation was required, and
ii. the in-patient hospitalisation claim for such hospitalisation is admissible by the Company

Pre hospitalisation shall be considered as part of the hospitalisation claim.

1.2.3 Post Hospitalisation

The Company shall reimburse the insured the medical expenses incurred up to sixty days immediately after the insured person is discharged from hospital, provided that:

i. such medical expenses are incurred for the same condition for which the insured person's hospitalisation was required, and
ii. the in-patient hospitalisation claim for such hospitalisation is admissible by the Company

Post hospitalisation shall be considered as part of the hospitalisation claim.

1.2.4 Day Care Procedure

The Company shall pay to the hospital/ day care centre the medical expenses or reimburse the insured the medical expenses and pre and post hospitalisation expenses, for day care procedures which require hospitalisation for less than twenty four hours, provided that

i. day care procedures/surgeries are undergone by an insured person in a hospital/day care centre (but not in the outpatient department of a hospital)

ii. any other surgeries/procedures which due to advancement of medical science require hospitalisation for less than twenty four hours and for which prior approval from the Company/TPA is mandatory.

1.2.5 Ayurveda and Homeopathy

The Company shall pay to the hospital the medical expenses or reimburse the insured the medical expenses and pre and post hospitalisation expenses, incurred for Ayurveda and Homeopathy treatment, provided the treatment is undergone in

i. a government hospital, or
ii. an institute recognized by the government and/or accredited by Quality Council of India/ National Accreditation Board for Health, or
iii. Teaching Hospitals of AYUSH Colleges recognized by Central Council of Indian Medicine (CCIM) and Central Council of Homeopathy (CCH), or
iv. AYUSH Hospitals having registration with a Government Authority under appropriate Act in the State/ UT and complies with the following as minimum criteria:
    a. Has at least fifteen in-patient beds;
    b. Has minimum five qualified and registered AYUSH doctors;
    c. Has qualified paramedical staff under its employment round the clock
    d. Has dedicated AYUSH therapy sections
    e. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel

1.2.6 Organ Donor's Medical Expenses

The Company shall pay to the hospital or reimburse the insured the medical expenses and pre and post hospitalisation expenses of the organ donor, during the course of organ transplant to the insured person, provided

i. the donation conforms to 'The Transplantation of Human Organs Act 1994' and the organ is for the use of the insured person
ii. the insured person has been medically advised to undergo an organ transplant,

Exclusions

The Company shall not be liable to make any payment in respect of any expenses incurred in connection with or in respect of

1. Cost of the organ to be transplanted.
2. Any other medical treatment or complication in respect of the donor, consequent to harvesting.

1.2.7 HIV Treatment

The Company shall pay to the hospital or reimburse the insured the medical expenses for treatment of HIV (Human Immunodeficiency Virus), AIDS (Acquired Immune Deficiency Syndrome), and complications of AIDS, after a waiting period of 3 months from the inception of the Policy. The stages of covered HIV infection are:

1. Acute HIV infection – acute flu-like symptoms
2. Clinical latency – usually asymptomatic or mild symptoms
3. AIDS – full-blown disease; CD4 < 200

Exclusions

The Company shall not be liable to make any payment in respect of any expenses incurred in connection with or in respect of treatment of HIV/AIDS pre-existing at inception of the Policy.

1.2.8 Morbid Obesity Treatment

The Company shall pay to the hospital or reimburse the insured the medical expenses for bariatric surgery/surgical intervention required for the treatment of Morbid Obesity, after a waiting period of 36 months from the inception of the Policy.
Bariatric surgery for the purpose of this section shall mean any medical procedures performed on people who have morbid obesity (i.e., BMI>40).

Exclusions

The Company shall not be liable to make any payment in respect of any expenses incurred for bariatric surgery in connection with or in respect of

1. Insured person less than 18 years of age
2. Infertility
3. Psychiatric disorder

1.2.9 Maternity

The Company shall pay to the hospital or reimburse the insured the medical expenses incurred for delivery or termination up to the first two deliveries or terminations of pregnancy during the lifetime of the insured or his spouse covered under the Policy, after a waiting period of 36 months from the date of inclusion of the insured person in the Policy. The benefits described below are up to the limit as shown in the Table of Benefits.

i. Medical expense for delivery (normal or caesarean).
ii. Medical expense for lawful medical termination of pregnancy.
iii. Hospitalisation expenses, if medically necessary, up to a maximum of thirty days for pre-natal and sixty days for post-natal treatment.

Note: Ectopic pregnancy is covered under Section 1.2.1 'In-patient treatment', provided such pregnancy is established by medical reports.

Exclusions

The Company shall not be liable to make any payment in respect of any expenses incurred in connection with or in respect of

1. Insured and insured persons above forty five years of age.
2. More than one delivery or termination in a policy period.
3. Surrogacy
4. Pre and post hospitalisation expenses as per Section 1.2.2 and Section 1.2.3, other than pre and post natal treatment.

1.3 Additional Benefits

Following benefits shall be payable only for claims admissible under the policy

1.3.1 Hospital Cash

The Company shall pay the insured a daily hospital cash allowance up to the limit as shown in the Table of Benefits for a maximum of five days, provided

i. the hospitalisation exceeds three days.
ii. a claim has been admitted under Section 1.2.1.

Illustration

In case of hospitalisation of 3 days, threshold not exhausted – No Hospital Cash payable
In case of hospitalisation of 5 days, threshold not exhausted – No Hospital Cash payable
In case of hospitalisation of 5 days, threshold exhausted – Hospital Cash payable for 4th and 5th day only, i.e., 2 days
In case of hospitalisation of 10 days, threshold exhausted – Hospital Cash payable for 4th to 8th day, i.e., maximum 5 days
Hospitalisation of less than 24 hours shall not be considered for the purpose of payment of Hospital Cash

1.3.2 Doctor's Home Visit/ Aya/ Nurse/ Attendant Charges during Post Hospitalisation

The Company shall reimburse the insured, for medically necessary expenses incurred for doctor's home visit, nursing care by qualified nurse, aya, attendant charges during post hospitalisation up to the limit as shown in the Table of Benefits., provided the related hospitalisation claim has been admitted under Section 1.2.1 and the physical mobility of the insured person outside residence is severely restricted due to the illness/ injury requiring hospitalization.

1.3.3 Ambulance Charges

The Company shall reimburse the insured the expenses incurred for actual emergency ambulance charges for transportation to the hospital, or from one hospital to another hospital, provided a claim has been admitted under Section 1.2.1. Ambulance charges will be paid once for any one illness for each insured person.

1.4 Migration to Policy without Threshold

The Company shall allow the insured persons to migrate to any indemnity health insurance product (for same or lower sum insured without any threshold) of the Company with continuity coverage in terms of waiver of waiting periods to the extent of benefits covered under this Policy, provided the insured person has been covered under National Super Top Up Mediclaim Policy before attaining the age of 45 years and has continuously renewed the Policy for 5 years without interruption.

Conditions

1. Migration to any other indemnity health insurance product shall be subject to the Underwriting Guidelines of the said product, including Pre Policy Health Checkup (if applicable).
2. This option can be exercised by the Insured Person at the time of renewal only.
3. Insured person has to apply to the Policy issuing office for the migration at least 45 days prior to the renewal date.
4. On migration, terms and rates of the migrated policy shall apply.

1.5 Good Health Incentives

1.5.1 Cumulative Bonus (CB)

At the time of renewal, cumulative bonus allowed shall be an amount equal to 5% (five percent) of sum insured (excluding CB) of the expiring policy in respect of an insured person (for Policy issued on individual basis) or family (for Policy issued on floater basis), provided no claims were reported under the expiring policy.

In the event of a claim being reported under the expiring policy the cumulative bonus with respect to the insured person/ family shall be reduced by an amount equal to 5% (five percent) of sum insured (excluding CB) of the expiring policy. However, the reduction of CB will not impact sum insured (excluding CB).

Cumulative bonus shall be aggregated over the years and available, subject to maximum of 50% (fifty percent) of the sum insured (excluding CB) of the current policy.

1.5.2 Health Check Up

Expenses of health check up with respect to the insured person(s), shall be reimbursed at the end of a block of two continuous policy periods, provided claims are not reported during the block in respect of the insured person(s) and the Policy has been continuously renewed with the Company without a break. Expenses payable are subject to the limit as shown in the Table of Benefits.

1.6 Hospitalisation Options

The Policy provides for cashless facility and/ or reimbursement of hospitalisation expenses for treatment of disease or injury.
Cashless facility is available only in network providers, if opted for TPA service, subject to prior approval by the TPA.

2.1 Eligibility

i. Policy can be opted on individual and floater basis. On floater basis, at least two family members, as defined below, shall be covered.
ii. Policy can be opted with or without a Base Policy (i.e., any Indemnity Based Health Insurance Product offered by any General Insurance Company covering the same members).
iii. Entry age of Proposer should be between eighteen years and sixty five years.
iv. Maximum entry age of any family member is sixty five years.
v. Children between the entry age of three months and eighteen years may be covered, provided parent(s) is/are covered at the same time.
vi. Family members allowed under same policy.
    a. Proposer
    b. Spouse
    c. Dependent legitimate or legally adopted children
    d. Parents/ Parents-in law
vii. Renewal terms are as per Section 2.10 below.
viii. Midterm inclusion of family members at pro-rata premium is allowed only in case of
    a. newborn between the age of three months and six months
    b. spouse within sixty days of marriage

(Members other than above may be included only at renewal. On inclusion of a new member, waiting period of 4.1, 4.2, 4.3 shall apply for the new member.)

2.3 Policy Period

The Policy can be issued for a period of one year.

2.4 Sum Insured (SI) and Threshold

i. The Policy is available with following combinations of Threshold and sum insured

Threshold	Sum Insured (above Threshold)
2L	3, 5L
3L	3, 5, 7L
5L	5, 7, 10L
8L	10, 15L
10L	15, 20L

ii. For Policy issued on individual basis, both Threshold and sum insured shall apply on individual basis on each insured person.
iii. For Policy issued on floater basis, both Threshold and sum insured shall apply on floater basis to all the insured persons.

2.3.1 Enhancement of Sum Insured, Threshold

i. Sum insured and/ or Threshold can be enhanced only at the time of renewal, to the next slab.
ii. For the incremental portion of the sum insured, the waiting periods and conditions as mentioned in exclusion 4.1, 4.2, 4.3 shall apply. Coverage on enhanced sum insured shall be available after the completion of waiting periods.

2.4 Discounts

2.4.1 Early Entry Discount (EED)

In case where an insured person has entered the policy before the age 42 (completed years) and renewed the policy for a continuous period of 3 years, an EED of 5% on individual premium will be allowed starting from the fourth policy period and continue in subsequent renewals during the life time of the Policy.

Illustration

	Scenario I	Scenario II	Scenario III
Age at inception of Policy 1	41 yrs 6 months	25 yrs 2 months	43 yrs 0 months
Age at inception of Policy 2	42 yrs 6 months	26 yrs 2 months	44 yrs 0 months
Age at inception of Policy 3	43 yrs 6 months	27 yrs 2 months	45 yrs 0 months
Age at inception of Policy 4	44 yrs 6 months	28 yrs 2 months	46 yrs 0 months
EED from Policy 4	**Applicable**	**Applicable**	**Not applicable**

2.4.2 Family Discount (applicable only to Policy issued on individual basis)

In case one or more of the family members are covered along with the proposer - Discount of 5% shall be allowed on the total family premium for new and renewal policies.

2.4.3 Discount for Online, Direct

For Policy bought online, by walk in customer *(where no intermediary is involved)* - Discount of 10% shall be allowed on the final payable premium for new and renewal policies.

2.5 Tax Rebate

The insured can avail tax benefits for the premium paid, under Section 80D of Income Tax Act 1961.

2.6 Buying the Policy

The Policy can be bought from the channels mentioned below.

i. online from http://niconline.in/, for policies where Pre Policy Checkup is not required.
ii. from our operating offices
iii. from our agents
iv. from self service kiosks
v. from Office on Wheels (office on mobile van)
vi. Any other channel introduced by the Regulator from time to time

2.7 Completion of Proposal Form

i. The proposal form is to be completed in all respects (including personal details, medical history of insured person) and to be submitted to the office or to the agent.
ii. Identity and address of the proposer must be supported by documentary proof.
iii. Details of Base Policy must be supported by documentary proof (for Policy issued with Base Policy)
iv. Person insured covered by any similar health insurance policy of any other general insurance Company and wishing to port (switch) to National Super Top Up Mediclaim Policy, will have to submit the proposal form and portability form to the office or to the agent.
v. If opting for Waiver of Threshold (Section 1.4), fresh Proposal Form applicable to new product shall be submitted.

2.8 Pre Policy Checkup

i. Pre Policy checkup is required for all individual family members
   a. Fifty years and above or
   b. Opting for SI 10L and above
ii. The Company shall reimburse 50% of the expenses incurred for pre Policy checkup, if the proposal is accepted and the premium has been realized.
iii. The Pre Policy checkup reports required are –
   a) Physical examination (report to be signed by the Doctor with minimum MD (Medicine) qualification)
   b) Blood sugar (fasting/ post prandial)
   c) Lipid profile
   d) Serum creatinine
   e) Urine routine and microscopic examination
   f) ECG
   g) Eye checkup (including retinoscopy)
   h) Any other investigation required by the Company

Note:

The date of medical reports should not exceed thirty days prior to the date of proposal.

2.9 Payment of Premium

i. For Policy issued on individual basis, premium depends on the SI opted and age of the member.
ii. For Policy issued on floater basis, premium depends SI opted, age of the senior most member and age of family members.
iii. The proposer has the option of claims being serviced by TPA (in which case cashless facility/reimbursement of expenses will be available) or the Company (in which case expenses will be reimbursed). If cashless facility is to be availed, the premium payable is inclusive of TPA charges. If cashless facility is not required, the premium payable is without TPA charges.
iv. PAN details must be submitted to the Company.
v. In case PAN is not available, Form 60 or Form 61 as per Rule 114B of the Income-tax Rule,1962 must be submitted

2.10 Renewal of Policy

i. The Policy can be renewed throughout the lifetime of all the insured persons, except the following.
   - Dependent male child only up to twenty five years, shall be allowed renewal if not employed.
   - Dependent female child if not employed, shall only be allowed renewal till marriage.
ii. Insured Children have the option to port to similar health insurance product on completion of the specified exit age as mentioned in 2.10.i.
iii. The Policy may be renewed by mutual consent before the expiry of the Policy.
iv. The Company is not bound to send renewal notice.
v. Renewal of Policy can be denied on grounds of fraud, moral hazard, misrepresentation or noncooperation.
vi. In the event of break in the Policy a grace period of thirty days is allowed. Coverage is not available during the grace period.
vii. In case of non-continuance of the Policy by the insured (due to death or any other valid and acceptable reason)
   - The Policy may be renewed by any insured person above eighteen years of age, as the insured
   - Where only children (less than eighteen years of age) are covered, the Policy shall be allowed till the expiry of the policy period. The legal guardian may be allowed to renew the Policy as insured, covering the children.
viii. In case of death of the eldest insured person in a Policy issued on floater basis,
   - The premium to be charged shall be based on the age of the next eldest insured person.
ix. If during the policy period, the number of members covered in a floater policy reduces to a single member, then on renewal the Policy shall automatically be converted to individual basis.

3 Definitions

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

3.2 AIDS or Acquired Immune Deficiency Syndrome is a disease in which there is a severe loss of the body's cellular immunity, greatly lowering the resistance to infection and malignancy. AIDS is caused by infection with HIV (Human Immuno Deficiency Virus).

3.3 Any One Illness means continuous period of illness and it includes relapse within forty five days from the date of last consultation with the hospital where treatment has been taken.

3.4 AYUSH Treatment refers to the medical and / or hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy systems.

3.5 Break in Policy occurs at the end of the existing policy period when the premium due for a given Policy is not paid on or before the renewal date or within grace period.

3.6 Body Mass Index (BMI) is defined as the body mass (weight) divided by the square of the height of an individual, and is universally expressed in units of kg/m2, resulting from mass in kilograms and height in metres.

3.7 Cashless Facility means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the Policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization approved.

3.8 Condition Precedent means a Policy term or condition upon which the Company's liability under the Policy is conditional upon.

3.9 Contract means prospectus, proposal, Policy, and the policy schedule. Any alteration with the mutual consent of the insured person and the insurer can be made only by a duly signed and sealed endorsement on the Policy.

3.10 Congenital Anomaly refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

a) Internal Congenital Anomaly

Congenital anomaly which is not in the visible and accessible parts of the body.

b) External Congenital Anomaly

Congenital anomaly which is in the visible and accessible parts of the body.

3.11 Cumulative Medical Expenses means the aggregate of medical expenses incurred during the policy period of this Policy towards one or more out of the Coverage mentioned in Section 1.2 (i.e. under the heads of 1.2.1. In-patient Treatment, 1.2.2. Pre Hospitalisation, 1.2.3. Post Hospitalisation, 1.2.4. Day Care Procedure, 1.2.5. Ayurveda and Homeopathy, 1.2.6. Organ Donor's Medical Expenses, 1.2.7. HIV Treatment, 1.2.8. Morbid Obesity Treatment & 1.2.9. Maternity) in respect of,

a) Individual Plan

The insured person for one or more hospitalisation during the policy period

b) Floater Plan

One or more insured persons for one or more hospitalisation during the policy period.

3.12 Day Care Centre means any institution established for day care treatment of disease/ injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:

i. has qualified nursing staff under its employment;
ii. has qualified medical practitioner (s) in charge;
iii. has a fully equipped operation theatre of its own where surgical procedures are carried out
iv. maintains daily records of patients and shall make these accessible to the Company's authorized personnel.

3.13 Day Care Treatment means medical treatment, and/or surgical procedure (as listed in Annexure I) which is:

i. undertaken under general or local anesthesia in a hospital/day care centre in less than twenty four hrs because of technological advancement, and
ii. which would have otherwise required a hospitalisation of more than twenty four hours.

Treatment normally taken on an out-patient basis is not included in the scope of this definition.

3.14 Dental Treatment means a treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery.

3.15 Diagnosis means diagnosis by a medical practitioner, supported by clinical, radiological, histological and laboratory evidence, acceptable to the Company.

3.16 Family Members means spouse, children and parents/ in laws of the insured, covered under the Policy.

3.17 Floater means the threshold/ sum insured, as mentioned in the Schedule, applicable to all the insured persons, for any and all claims made in aggregate during the policy period.

3.18 Grace Period means thirty days immediately following the premium due date during which a payment can be made to renew or continue the Policy in force without loss of continuity benefits such as waiting period and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

3.19 Hospital means any institution established for in-patient care and day care treatment of disease/ injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under 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 ten inpatient beds, in those towns having a population of less than ten lacs and fifteen inpatient 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 shall make these accessible to the Company's authorized personnel.

3.20 Hospitalisation means admission in a hospital for a minimum period of twenty four (24) consecutive 'Inpatient care' hours except for specified procedures/ treatments, where such admission could be for a period of less than twenty four (24) consecutive hours.

3.21 ID Card means the card issued to the insured person by the TPA for availing cashless facility in the network provider.

3.22 Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the policy period and requires medical treatment.

i. **Acute Condition** means a disease, illness or injury that is likely to response 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.
ii. **Chronic Condition** means a disease, illness, or injury that has one or more of the following characteristics
    a) it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
    b) it needs ongoing or long-term control or relief of symptoms
    c) it requires rehabilitation for the patient or for the patient to be special trained to cope with it
    d) it continues indefinitely
    e) it recurs or is likely recur

3.23 In-Patient Care means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

3.24 Insured/ Insured Person means person(s) named in the schedule of the Policy.

3.25 Intensive Care Unit means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

3.26 ICU (Intensive Care Unit) Charges means the amount charged by a Hospital towards ICU expenses on a per day basis which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

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

3.28 Medical Advice means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.

3.29 Medical Expenses means those expenses that an insured person has necessarily and actually incurred for medical treatment on account of illness or accident on the advice of a medical practitioner, as long as these are no more than would have been payable if the insured person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

3.30 Medically Necessary 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 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.

3.31 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 the scope and jurisdiction of the licence.

3.32 Morbid Obesity is a medical term describing people who have a Body Mass Index (BMI) of at least 40 and with significant medical problems caused by or made worse by their weight.

3.33 Network Provider means hospitals or health care providers enlisted by insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a cashless facility.

3.34 Non- Network means any hospital, day care centre or other provider that is not part of the network.

3.35 Notification of Claim means the process of intimating a claim to the Insurer or TPA through any of the recognized modes of communication.

3.36 Out-Patient Treatment means treatment in which the insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a medical practitioner. The insured is not admitted as a day care or in-patient.

3.37 Policy Period means period of one year as mentioned in the schedule for which the Policy is issued.

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

3.39 Pre-hospitalisation Medical Expenses means medical expenses incurred during predefined number of days preceding the hospitalisation of the Insured Person, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and

ii. The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.

3.40 Post-hospitalisation Medical Expenses means medical expenses incurred during predefined number of days immediately after the insured person is discharged from the hospital provided that:

i. Such Medical Expenses are for the same condition for which the insured person's hospitalisation was required, and

ii. The inpatient hospitalisation claim for such hospitalisation is admissible by the Insurance Company.

3.41 Qualified Nurse means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

3.42 Reasonable and Customary Charges means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness/ injury involved.

3.43 Room Rent means the amount charged by a hospital towards Room and Boarding expenses and shall include the associated medical expenses.

3.44 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.

3.45 Schedule means a document forming part of the Policy, containing details including name of the insured person, age, relation of the insured person, sum insured, premium paid and the policy period.

3.46 Sum insured means the sum insured and the cumulative bonus (CB) accrued in respect of the insured person (for policies issued on individual basis)/ one or more insured persons (for policies issued on floater basis) as mentioned in the schedule. The sum insured represents maximum liability of the Company for any and all claims during the policy period. Health checkup expenses are payable over and above the sum insured, wherever applicable.

3.47 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 and prolongation of life, performed in a hospital or day care centre by a medical practitioner.

3.48 Threshold means the amount of Cumulative Medical Expenses (as per Definition 3.11), as chosen by the insured and mentioned in the schedule, up to which no amount can be claimed under this Policy.

3.49 Third Party Administrator (TPA) means a company registered with the Authority, and engaged by an insurer, for a fee or remuneration, by whatever name called and as may be mentioned in the agreement, for providing health services.

Note: *If opted for TPA service, TPA details are mentioned in the Policy Schedule.*

3.50 Unproven/ Experimental Treatment means treatment, including drug experimental therapy, which is not based on established medical practice in India, is experimental or unproven.

3.51 Waiting Period means a period from the inception of this Policy during which specified diseases/treatment is not covered. On completion of the period, diseases/treatment shall be covered provided the Policy has been continuously renewed without any break.

4 Exclusions

The Company shall not be liable to make any payment under the Policy, in respect of any expenses incurred in connection with or in respect of:

4.1 Pre-Existing Diseases

All pre-existing diseases. Any complication arising from pre-existing diseases shall be considered as a part of the pre-existing disease. Such diseases or complications thereof shall be covered after the Policy has been continuously in force for twelve months, as per the table given below.

Months from inception	Limit of claim
13-24 months	50% of the admissible claim
25-36 months	75% of the admissible claim
After 36 months	100% of the admissible claim

Illustration of pre-existing disease and related complication

For persons suffering from either hypertension or diabetes or both at the inception of the Policy, related complications as per the following table shall be considered as pre-existing diseases.

Diabetes	Hypertension	Diabetes and Hypertension
Diabetic Retinopathy	Coronary Artery Disease	Diabetic Retinopathy
Diabetic Nephropathy	Cerebro Vascular Accident	Diabetic Nephropathy
Diabetic Foot/wound	Hypertensive Nephropathy	Diabetic Foot/wound
Diabetic Angiopathy	Internal Bleeding/ Haemorrhage	Diabetic Angiopathy
Diabetic Neuropathy		Diabetic Neuropathy
Hyper/Hypoglycemic shock		Hyper/Hypoglycemic shock
Coronary Artery Disease		Coronary Artery Disease
		Cerebro Vascular Accident
		Hypertensive Nephropathy
		Internal Bleeding/ Haemorrhage

4.2 First Thirty Days Waiting Period

Any disease contracted by the insured person during the first thirty days from the inception of the Policy. The waiting period shall not apply in case of renewal and if the insured person is hospitalised for injuries, sustained in an accident which occurred after the inception of the Policy.

4.3 Specific Waiting Period

Diseases/treatments listed below are subject to waiting periods as follows.

i. **One year waiting period**

a. Benign ENT disorders
b. Tonsillectomy
c. Adenoidectomy
d. Mastoidectomy
e. Tympanoplasty
f. Cataract
g. Benign prostatic hypertrophy
h. Hernia
i. Hydrocele
j. Fissure/Fistula in anus
k. Piles (Haemorrhoids)
l. Sinusitis and related disorders
m. Polycystic ovarian disease
n. Non-infective arthritis
o. Pilonidal sinus
p. Gout and Rheumatism
q. Hypertension and related complications as mentioned in 4.1
r. Diabetes and related complications as mentioned in 4.1
s. Calculus diseases
t. Surgery of gall bladder and bile duct excluding malignancy
u. Surgery of genito-urinary system excluding malignancy
v. Surgery for prolapsed intervertebral disc unless arising from accident
w. Surgery of varicose vein
x. Hysterectomy

ii. **Two years waiting period**

Following diseases even if pre-existing shall be covered after two years of continuous cover from the inception of the Policy.

a. Treatment for joint replacement unless arising from accident
b. Osteoarthritis and osteoporosis

After expiry of twenty four months any claim arising out of the above conditions or complications thereof will be paid as per the table given below

Months from inception	Limit of claim
25-36 months	75% of the admissible claim
After 36 months	100% of the admissible claim

4.4 STD
Any condition directly or indirectly caused to or associated with sexually transmitted diseases (STD), except as and to the extent provided for under Section 1.2.7 (HIV Treatment).

4.5 General Debility, Congenital External Anomaly
General debility, run down condition or rest cure, congenital external disease or defects or anomaly.

4.6 Sterility, Infertility, Assisted Conception
Sterility, infertility/sub fertility, assisted conception procedures.

4.7 Pregnancy
Treatment arising from or traceable to pregnancy/childbirth including caesarean section, miscarriage, surrogate or vicarious pregnancy, abortion or complications thereof including changes in chronic conditions arising out of pregnancy other than ectopic pregnancy which may be established by medical reports), except as and to the extent provided for under Section 1.2.9 (Maternity).

4.8 Refractive Error
Surgery for correction of eye sight due to refractive error.

4.9 Obesity
Treatment for obesity and any other weight control and management programme/services/supplies or treatment), except as and to the extent provided for under Section 1.2.8 (Bariatric Surgery).

4.10 Psychiatric Disorder, Self Inflicted Injury
Treatment for all psychiatric and psychosomatic disorders/diseases, intentional self-inflicted injury, attempted suicide.

4.11 Stem Cell Surgery (except bone marrow transplant).

4.12 Circumcision
Circumcision, except as and to the extent provided for under Section 1.2.1.xi

4.13 Vaccination or Inoculation
Vaccination or inoculation unless forming part of treatment and requires hospitalisation.

4.14 Cosmetic Treatment, Plastic Surgery, Sex Change, Hormone Replacement Therapy
Cosmetic treatment or aesthetic treatment of any description, change of life or sex change operation.
Expenses for plastic surgery, except as and to the extent provided for under Section 1.2.1.viii.
Expenses for hormone replacement therapy, except as and to the extent provided for under Section 1.2.1.ix.

4.15 Massages, Spa, Steam Bath, Naturopathy, Experimental Treatment
Massages, spa, steam bath, shirodhara, udhwarthanam, abhyangam, kayasekham and similar treatment.
Expenses for naturopathy, experimental medicine/treatment, unproven procedure/treatment, AYUSH treatments (other than ayurveda and homeopathy) acupuncture, acupressure, magneto-therapy and similar treatment.

4.16 Dental Treatment
Dental treatment, except as and to the extent provided for under Section 1.2.1.vii.

4.17 Vitamins, Tonics
Vitamins and tonics, except as and to the extent provided for under Section 1.2.1.x.

4.18 Out-patient Treatment
Any treatment undergone as an out-patient.

4.19 Hospitalisation for the Purpose of Diagnosis and Evaluation
Diagnostic and evaluation purpose where such diagnosis and evaluation can be carried out as an outpatient procedure and the condition of the patient does not require hospitalisation.

4.20Treatment in Convalescent Home, Nature Clinic
Treatment in health hydro/nature care clinic rest home or convalescent home for the addicted, detoxification centre, sanatorium, home for the aged, mentally disturbed, remodeling clinic or similar institution.

4.21 Drug/Alcohol Abuse

Treatment arising out of disease/ injury directly attributable to abuse of drugs/alcohol and intoxicating substances.

4.22 Stay in Hospital which is not Medically Necessary.

4.23 Spectacles, Contact Lens, Hearing Aid, Cochlear Implants.

4.24 Equipments
External/durable medical/non-medical equipments/instruments of any kind used for diagnosis/ treatment including CPAP, CAPD, infusion pump, ambulatory devices such as walker, crutches, belts, collars, caps, splints, slings, braces, stockings, diabetic foot-wear, glucometer, thermometer and similar related items (as listed in Appendix II) and any medical equipment which could be used at home subsequently.

4.25 Expenses not Related to the Diagnosis and Treatment of Disease/ Injury
Irrelevant investigations/treatment, drugs not supported by a prescription, private nursing charges, referral fee to family physician, outstation doctor/surgeon/consultants' fees and similar expenses.

4.26 Items of Personal Comfort
Items of personal comfort and convenience including telephone, television, aya, barber, beauty services, baby food, cosmetics, napkins, toiletries, guest services.

4.27 Service Charge/ Registration Fee
Any kind of service charges including surcharges, admission fees, registration charges and similar charges levied by the hospital.

4.28 Home Visit Charges
Home visit charges during pre and post hospitalisation of doctor, attendant and nurse, except as and to the extent provided for under Section 1.3.2 (Doctor's Home Visit/ Aya/ Nurse/ Attendant charges during Post Hospitalisation).

4.29 Treatment not Related to Disease
Treatment which the insured person was on before hospitalisation for the disease/ injury, different from the one for which claim for hospitalisation has been made.

4.30 Risky Avocations
Treatment for any disease/injury arising from scuba diving, motor racing, parachuting, hang gliding, rock or mountain climbing and similar activities.

4.31 Breach of Law
Any disease or injury as a result of committing or attempting to commit a breach of law with criminal intent.

4.32 War Group Perils
Any disease or injury directly or indirectly caused by or arising from or attributable to war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalisation or requisition of or damage by or under the order of any government or public local authority.

4.33 Radioactivity
Any disease or injury directly or indirectly caused by or contributed by nuclear weapons/materials or arising from ionising radiation or contamination by any nuclear fuel or from any nuclear waste or combustion of nuclear fuel.

5 Policy Conditions

5.1 Disclosure of Information
The Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of mis-representation, mis-description or non-disclosure of any material fact.

5.2 Condition Precedent to Admission of Liability
The due observance and fulfillment of the terms and conditions of the Policy, by the insured, shall be a condition precedent to any liability of the Company to make any payment by the Policy.

5.3 Communication
i. All communication should be made in writing.
ii. For Policies serviced by TPA, ID card, network provider related issues to be communicated to the TPA at the address mentioned in the schedule. For claim serviced by the Company, the Policy related issues to be communicated to the Policy issuing office of the Company at the address mentioned in the schedule.
iii. Any change of address, state of health or any other change affecting any of the insured person, shall be communicated to the Policy issuing office of the Company at the address mentioned in the schedule
iv. The Company or TPA shall communicate to the insured at the address mentioned in the schedule.

5.4 Physical examination

Any medical practitioner authorised by the Company shall be allowed to examine the insured person in the event of any alleged injury or disease requiring hospitalisation when and as often as the same may reasonably be required on behalf of the Company.

5.5 Claim Procedure

5.5.1 Condition Precedent to Claim

1. Claim shall be admissible for the hospitalisation during which the cumulative medical expenses as per Section 1.2 in respect of hospitalisation(s) of any insured person (individual plan) or one or more insured person (floater plan)in a policy period exceeds the threshold as per Section 1.2 and for all subsequent hospitalisation(s) during the policy period.
2. Admissible claim amount for hospitalisation(s) mentioned above shall be calculated as per Section 1.2 and Section 1.3.

5.5.2 Notification of Claim

In order to lodge a claim under the Policy for any hospitalisation during the policy period, the insured person/insured person's representative shall notify the TPA (if claim is processed by TPA)/Company (if claim is processed by the Company) in writing by letter, e-mail, fax providing all relevant information relating to claim including plan of treatment, policy number etc. within the prescribed time limit.

Notification of claim for Cashless facility	**TPA must be informed:**
In the event of planned hospitalisation	At least seventy two hours prior to the insured person's admission to network provider
In the event of emergency hospitalisation	Within twenty four hours of the insured person's admission to network provider

Notification of claim for Reimbursement	**Company/TPA must be informed:**
In the event of planned hospitalisation	At least seventy two hours prior to the insured person's admission to hospital
In the event of emergency hospitalisation	Within twenty four hours of the insured person's admission to hospital

Note:

i. In case of hospitalisation where the cumulative medical expenses are likely to exceed the threshold, notification of claim shall be sent to the TPA mentioned in the schedule/ Company.
ii. In case of hospitalisation where initially the cumulative medical expenses are not foreseen to exceed the threshold but subsequently exceeds, notification of claim shall be sent to the TPA mentioned in the schedule/ Company, immediately.

5.5.3 Procedure for Cashless Claims

i. **Cashless facility shall not be available for the first claim under the Policy (i.e., the claim in which cumulative medical expenses exceeds the threshold). However, for all subsequent claims cashless facility shall be available subject to sl. no ii to viii below.**
ii. Cashless facility for treatment in network hospitals can be availed, if TPA service is opted.
iii. Treatment may be taken in a network provider and is subject to pre authorization by the TPA. Booklet containing list of network provider shall be provided by the TPA. Updated list of network provider is available on website of the Company and the TPA mentioned in the schedule.
iv. Cashless request form available with the network provider and TPA shall be completed and sent to the TPA for authorization.
v. The TPA upon getting cashless request form and related medical information from the insured person/ network provider shall issue pre-authorization letter to the hospital after verification.
vi. At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.
vii. The TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details.
viii. In case of denial of cashless access, the insured person may obtain the treatment as per treating medical practitioner's advice and submit the claim documents to the TPA for processing.

5.5.4 Procedure for Reimbursement of Claims

For reimbursement of claims the insured person may submit the necessary documents to TPA (if claim is processed by TPA)/Company (if claim is processed by the Company) within the prescribed time limit.

5.5.5 Documents

The claim is to be supported by the following documents in original and submitted within the prescribed time limit.

i. Completed claim form
ii. Medical practitioner's prescription advising admission for inpatient treatment.
iii. Bills, receipt from the hospital(s)/ chemist(s) supported by prescription from attending medical practitioner for period of pre hospitalization, hospitalization and post hospitalization (if applicable)
iv. Bills, receipt, investigation test reports etc. supported by prescription from attending medical practitioner for period of pre hospitalization, hospitalization and post hospitalization (if applicable)
v. Attending medical practitioner's certificate regarding diagnosis along with date of diagnosis and bill, receipts etc.
vi. Certificate from the surgeon regarding diagnosis and nature of operation and bills, receipts etc.

vii. Bills, receipt, Sticker of the Implants.
viii. Bills, payment receipts, medical history of the patient recorded, indoor case papers, discharge certificate/ summary, break up of final bill from the hospital etc.
ix. Documents as listed under Sl. No (ii) to (viii) relating to previous hospitalisation(s) in the policy period along with claim settlement advice (if any), in original or certified copy.
x. Any other document required by Company/TPA

Note

1. **The insured shall preserve and submit all original documents and/ or certified copies of documents related to all hospitalisation(s) during the policy period to enable the Company to calculate the cumulative medical expenses and threshold, for determining admissibility and payment of claims.**
2. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the documents listed under condition 5.5.5 duly certified by the said insurer along with claim settlement advice, subject to satisfaction of the Company.

Type of claim	**Time limit for submission of documents to Company/TPA**
Reimbursement of hospitalisation, pre hospitalisation expenses and ambulance charges	Within fifteen days from date of discharge from hospital
Reimbursement of post hospitalisation expenses	Within fifteen days from completion of post hospitalisation treatment
Reimbursement of health checkup expenses (to be submitted to the office only)	Within six months of the third policy period.

5.5.6 Claim Settlement

i. On receipt of the final document(s) and investigation report (if required), 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 document(s) and investigation report (if required).
iii. Upon the acceptance of an offer of settlement by the insured, the payment of the amount of claim shall be made within seven days from the date of acceptance of the offer by the Company.
iv. In the cases of delay in the payment, the Company shall pay interest at a rate 2% above the bank rate prevalent at the beginning of the financial year in which the claim is paid.

5.5.7 Services Offered by TPA

Servicing of claims under health insurance policies by way of pre-authorization of cashless treatment or settlement of claims other than cashless claims or both, as per the underlying terms and conditions of the respective policy and within the framework of the guidelines issued by the insurers for settlement of claims.

The services offered by a TPA shall not include

i. Claim settlement and claim rejection; however, TPA may handle claims admission and recommend to the Company for settlement of the claim
ii. Any services directly to any insured person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company.

Waiver

Time limit for notification of claim and submission of documents may be waived in cases where it is proved to the satisfaction of the Company, that the physical circumstances under which insured person was placed, it was not possible to intimate the claim/submit the documents within the prescribed time limit.

5.6 Payment of Claim

All claims by the Policy shall be payable in Indian currency and through NEFT/ RTGS only.

5.7 Territorial limit

All medical treatment for the purpose of this insurance will have to be taken in India only.

5.8 Multiple Policies

If two or more policies are taken by an insured during a period from one or more companies to indemnify treatment costs, the insured shall have the right to require a settlement of his/her claim in terms of any of his/her policies.

1. In all such cases the company who has issued the chosen policy shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
2. Claims under other policy/ies may be made for the amount disallowed under the chosen policy irrespective of exhaustion of sum insured in the chosen policy
3. If the amount to be claimed exceeds the sum insured under a single policy after considering the threshold or co-pay, the insured shall have the right to choose companies from whom he/she wants to claim the balance amount.
4. Where an insured has policies from more than one company to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalisation costs in accordance with the terms and conditions of the chosen policy.

5.9 Fraud

The Company shall not be liable to make any payment under if the same is in any manner fraudulent or supported by any fraudulent means or device whether by the insured person or by any other person acting on his behalf.

5.10 Cancellation

i. The Company may at any time cancel the Policy (on the grounds of fraud, moral hazard, misrepresentation or noncooperation) by sending the insured thirty days' notice by registered letter at insured's last known address, and in such an event, the Company shall not allow any refund.

ii. The insured may at any time cancel the Policy and in such an event, the Company shall allow refund of premium after charging premium at Company's short period rate mentioned below, provided claims are not reported up to the date of cancellation.

Period of risk	**Rate of premium to be charged**
Up to 1month	1/4 of the annual rate
Up to 3 months	1/2 of the annual rate
Up to 6 months	3/4 of the annual rate
Exceeding 6 months	Full annual rate

5.11 Territorial Jurisdiction

All disputes or differences under or in relation to the Policy shall be determined by an Indian court in accordance to Indian law.

5.12 Arbitration

i. If any dispute or difference shall arise as to the quantum to be paid by 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 here to or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising 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, as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).

ii. 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 the Policy.

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

5.13 Disclaimer

If the Company shall disclaim liability for a claim hereunder and if the insured person shall not within twelve calendar months from the date of receipt of the notice of such disclaimer notify the Company in writing that he/ she does not accept such disclaimer and intends to recover his/ her claim from the Company, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

5.14 Renewal of Policy

The Policy may be renewed by mutual consent. The Company is not bound to give notice that the Policy is due for renewal. Renewal of the Policy cannot be denied other than on grounds of fraud, moral hazard, misrepresentation or noncooperation. In the event of break in the Policy a grace period, of thirty days is allowed. Cover is not available during the grace period.

5.15 Enhancement of Sum Insured, Threshold

Sum insured and/ or Threshold can be enhanced only at the time of renewal. Sum insured may be enhanced to the next slab subject to the discretion of the Company. For the incremental portion of the sum insured, the waiting periods and conditions as mentioned in exclusion 4.1, 4.2, 4.3 shall apply. Coverage on enhanced sum insured shall be available after the completion of waiting periods.

5.16 Adjustment of Premium for Overseas Travel Insurance Policy

If during the policy period any of the insured person is also covered by an Overseas Travel Insurance Policy of any general insurance company, the Policy shall be inoperative in respect of the insured persons for the number of days the Overseas Travel Insurance Policy is in force and proportionate premium for such number of days shall be adjusted against the renewal premium. The insured person must inform the Company in writing before leaving India and may submit an application, stating the details of visit(s) abroad, along with copies of the Overseas Travel Insurance Policy, within seven days of return or expiry of the Policy, whichever is earlier.

5.17 Portability

In the event of the insured person porting to any other insurer, insured person must apply with details of the Policy and claims to the insurer where the insured person wants to port, at least forty five days before the date of expiry of the Policy.

Portability shall be allowed only to similar policies, in the following cases:

i. all individual health insurance policies issued by non-life insurance companies including family floater policies.

ii. individual members, including the family members covered under any group health insurance policy of a non-life insurance Company shall have the right to migrate from such a group policy to an individual health insurance policy or a family floater policy with the same insurer. One year thereafter, the insured person shall be accorded the right to port to another non-life insurance Company.

5.18 Withdrawal of Product
In case the Policy is withdrawn in future, the Company shall provide options to the insured person to switch over to a similar Policy at terms and rates applicable to the new policy.

5.19 Revision of Terms of the Policy Including the Premium Rates
The Company, in future, may revise or modify the terms of the Policy including the premium rates based on experience. The insured shall be notified three months before the changes are effected.

5.20 Free Look Period
The Free Look Period shall be applicable at the inception of the Policy.
The insured shall be allowed a period of fifteen days from date of receipt of the Policy to review the terms and conditions of the Policy, and to return the same if not acceptable.
If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges; or
ii. where the risk has already commenced and the option of return of the Policy is exercised by the insured, a deduction towards the proportionate risk premium for period on cover

5.21 Nomination
The insured is mandatorily required at the inception of the Policy to make a nomination for the purpose of payment of claims by the Policy in the event of death of the insured. Any change of nomination shall be communicated to the Company in writing and such change shall be effective only when an endorsement on the Policy is made. In the event of death of any insured person other than the insured, for the purpose of payment of claims, the default nominee would be the insured. The Policy or the benefits cannot be assigned.

Categorization policy conditions	**Condition number**
Conditions precedent to the contract	5.1, 5.2, 5.21
Conditions applicable during the contract	5.3, 5.7, 5.9, 5.10. 5.11, 5.20
Conditions when a claim arises	5.4, 5.5, 5.6, 5.8, 5.12, 5.13
Conditions for renewal of the contract	5.14, 5.15, 5.16, 5.17, 5.18, 5.19

6 Redressal of Grievance
Grievance Level 1 – In case of any grievance relating to servicing the Policy, the insured person may submit in writing to the Policy issuing office or regional office for redressal.
Grievance Level 2 – If the grievance remains unaddressed, insured person may contact Customer Relationship Management Dept., National Insurance Company Limited, Chhabildas Towers, 6A, Middleton Street, Kolkata - 700071.
Grievance Level 3 – If the insured person is not satisfied, the grievance may be referred to "Health Insurance Management Dept.", National Insurance Company Limited, 3 Middleton Street, Kolkata - 700071.
For more information on grievance mechanism, and to download grievance form, visit our website www.nationalinsuranceindia.com.
IRDAI Integrated Grievance Management System - https://igms.irda.gov.in/
Insurance Ombudsman – The insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance.

7 Disclaimer
The prospectus contains salient features of the Policy. For details reference is to be made to the Policy. In case of any difference between the prospectus and the Policy, the terms and conditions of the Policy shall prevail.
The prospectus and proposal form are part of the Policy. Hence please read the prospectus carefully and sign the same. The proposal form is to be completed in all respects for each insured person. Both the prospectus and the proposal form are to be submitted to the office or to the agent.

Place **Signature**

Date **Name**

Insurance is the subject matter of solicitation.
No loading shall apply on renewals based on individual claims experience

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<tr><td>3 Lakhs</td><td>3, 5, 7 Lakhs</td></tr>
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<tr><td colspan="3">Discounts</td></tr>
<tr><td>Early Entry Discount</td><td>5% on individual premium</td><td>5% on individual premium</td></tr>
<tr><td>Family discount</td><td>5 % (in individual policy only)</td><td>NA</td></tr>
<tr><td>Online/ Direct Discount</td><td>10% (for new and renewal, where no intermediary is involved)</td><td>10% (for new and renewal, where no intermediary is involved)</td></tr>
</table>

* Aggregate of all the benefits under ‘*Coverage’* in a policy period are subject to the Threshold.
** Aggregate of all the benefits under ‘*Coverage’* and ‘*Additional Benefits’* for admissible claims in a policy period are subject to the Sum Insured opted.

Rate Chart (in INR)

Premium (INR) per Individual (for ind policy)/ Senior most member (for floater policy)

Threshold	2 lakhs		3 lakhs			5 lakhs			8 lakhs		10 lakhs	
Sum Insured	3 lakhs	5 lakhs	3 lakhs	5 lakhs	7 lakhs	5 lakhs	7 lakhs	10 lakhs	10 lakhs	15 lakhs	15 lakhs	20 lakhs
Age Group												
0 – 5*	920	1,251	793	1,077	1,196	737	903	1,244	1,122	1,436	903	1,077
6 - 17*	920	1,251	793	1,077	1,196	737	903	1,244	1,122	1,436	903	1,077
18 - 25	1,955	2,463	1,444	1,870	2,046	1,090	1,336	1,838	1,658	2,122	1,334	1,591
26 - 35	2,014	2,525	1,472	1,898	2,073	1,090	1,336	1,839	1,658	2,122	1,334	1,591
36 - 40	2,540	3,190	1,864	2,408	2,632	1,391	1,705	2,348	2,117	2,710	1,703	2,032
41 - 45	2,540	3,190	1,864	2,408	2,632	1,391	1,705	2,348	2,117	2,710	1,703	2,032
46 - 50	3,997	5,137	3,077	4,039	4,438	2,473	3,032	4,174	3,765	4,819	3,029	3,614
51 - 55	4,900	6,365	3,855	5,097	5,612	3,196	3,918	5,394	4,867	6,229	3,916	4,671
56 - 60	5,187	6,871	4,246	5,684	6,282	3,711	4,550	6,264	5,653	7,235	4,548	5,425
61 - 65	8,117	10,858	6,775	9,124	10,103	6,068	7,440	10,244	9,245	11,831	7,437	8,872
66 - 70	10,215	13,736	8,615	11,638	12,898	7,814	9,580	13,190	11,905	15,236	9,577	11,425
71 - 75	13,420	18,093	11,375	15,390	17,064	10,380	12,726	17,522	15,815	20,239	12,722	15,177
76 - 80	13,695	18,466	11,612	15,712	17,421	10,600	12,996	17,893	16,150	20,668	12,992	15,499
81 - 85	13,695	18,466	11,612	15,712	17,421	10,600	12,996	17,893	16,150	20,668	12,992	15,499
>=86	13,695	18,466	11,612	15,712	17,421	10,600	12,996	17,893	16,150	20,668	12,992	15,499

GST extra
** 0-5 & 6-17 age groups not applicable in Floater option*

Premium (INR) for additional family member (for floater policy)

Threshold	2 lakhs		3 lakhs			5 lakhs			8 lakhs		10 lakhs	
Sum Insured	3 lakhs	5 lakhs	3 lakhs	5 lakhs	7 lakhs	5 lakhs	7 lakhs	10 lakhs	10 lakhs	15 lakhs	15 lakhs	20 lakhs
Age Group												
0 - 5	123	168	106	144	160	99	121	167	150	192	121	144
6 - 17	135	184	117	158	176	108	133	183	165	211	133	158
18 - 25	307	387	227	294	321	171	210	289	260	333	209	250
26 - 35	340	427	249	321	350	184	226	311	280	359	225	269
36 - 40	617	775	453	585	640	338	414	570	515	658	414	494
41 - 45	617	775	453	585	640	338	414	570	515	658	414	494
46 - 50	1,395	1,793	1,074	1,410	1,549	863	1,058	1,457	1,314	1,682	1,057	1,261
51 - 55	1,710	2,221	1,345	1,779	1,959	1,116	1,368	1,883	1,699	2,174	1,367	1,630
56 - 60	2,091	2,769	1,711	2,291	2,532	1,496	1,834	2,524	2,278	2,916	1,833	2,186
61 - 65	4,058	5,429	3,387	4,562	5,051	3,034	3,720	5,122	4,623	5,916	3,719	4,436
66 - 70	5,301	7,129	4,471	6,040	6,694	4,055	4,972	6,846	6,179	7,907	4,970	5,930
71 - 75	7,234	9,752	6,131	8,295	9,198	5,595	6,859	9,444	8,524	10,909	6,857	8,181
76 - 80	7,669	10,341	6,503	8,799	9,756	5,936	7,278	10,020	9,044	11,574	7,275	8,679
81 - 85	7,957	10,729	6,747	9,129	10,122	6,158	7,551	10,396	9,383	12,008	7,548	9,005
>=86	8,902	12,003	7,548	10,213	11,324	6,890	8,447	11,631	10,498	13,434	8,445	10,074

GST extra

The premiums rates given above are all inclusive of TPA charges.
For without TPA – 6% discount on the premiums tabulated above.

Discounts
Early Entry Discount (EED) – 5% on individual premium
Family Discount – 5% on total family premium
Online Discount – 10% on total payable premium